

**Patient Registration Form**

Account number: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Department: \_\_\_\_\_

SSN: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_

Email address: \_\_\_\_\_

Sex: M\_\_F\_\_ Age: \_\_\_ Birth date: \_\_\_\_\_

\_\_\_Married \_\_\_Widowed \_\_\_Single \_\_\_Separated

\_\_\_Minor \_\_\_Divorced \_\_\_Full Time Student

Whom may we thank for referring you?

\_\_\_\_\_

How did you learn about us? \_\_\_Website\_\_\_Friend\_\_\_Relative

\_\_\_Yellow Pages

**If Minor, Responsible Party Parent/Guardian Information:**

Fathers Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Department: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Drivers Lic.#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\*\*\*\*\*

Mothers Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Department: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Drivers Lic.#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Primary Dental Carrier Information**

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relation: \_\_\_\_\_

**Secondary Dental Carrier Information**

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relation: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Physicians name: \_\_\_\_\_ Phone \_\_\_\_\_

**Person responsible for payment**

Name: \_\_\_\_\_

Method of Payment: \_\_\_Cash \_\_\_Check \_\_\_MasterCard \_\_\_Visa

\_\_\_Discover \_\_\_American Express \_\_\_Care Credit or CapitalOneFinance

I/We hereby assign James O. Glaser, DDS PC all rights and benefits pertaining to services rendered under any insurance policies and I/We authorize My/Our Physician to release whatever medical information is necessary to file said insurance claim. I/We, jointly and severally promise to pay My/Our account when due and if My/Our account is referred to a collection agency or attorney for collection that I/We agree to pay all costs of collection and expense including, but not limited to any collection agency and /or attorney fees of not less than twenty-five percent (25%) and court costs whichever are applicable, I/We waive the benefit of the Homestead Exemption.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/Parent/Legal Guardian

\_\_\_\_\_  
Date

