PEAK
FAMILY DENTISTRY & ORTHODONTICS

Patient Registration Form

Personal Information

Patient_____
First Name Initial Last Name
Responsible Party (If someone other than the patient)
_____
First Name Initial Last Name
Address_____
City _____ State _____Zip_____
Home Phone _____ Work _____ Cell _____
Birth Date_____Social Security _____ Drivers License_____
Email Address _____ check if you would like to receive email reminders and promotions
Sex: Male _____ Female_____

Emergency Contact

Name _____ Relation_____
Phone number _____ Phone number _____

Employer Information of Subscriber Insurance

Employers Name _____Phone number _____
Address_____
City _____ State _____ Zip_____
Full time student Yes___ No ____Where_____

Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)

Subscribers Name _____ Social Security _____ DOB _____
Insurance Company _____Plan Name _____
Phone nNmber_____Address_____
City _____ State _____ Zip _____
Group Number _____ Policy Number _____

Secondary Insurance Information

Subscribers Name _____Social Security _____
Insurance Company _____ Plan Name _____
Address _____
City _____ State _____ Zip _____
Group Number _____ Policy Number_____

Referral source

How did you hear about us?_____

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Your portion of the bill will be due at time of service. If your insurance has not paid within 60 days from the date from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party. I understand that, due to any false information, I will be subject to criminal prosecution

_____
Date Signature of patient (responsible party of minor)

*We are preferred providers with the following companies**: Aetna, Assurant/DHA, Blue Cross Blue Shield, Cigna, Delta Dental, Dentemax, Guardian, MetLife, Principal, United Concordia, and United Healthcare.***

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