Patient Registration Form
Dr. Drew Griffith

1. **General Information**

Name: ______________________________
First Last M.I
Home Address: ____________________
( ) Male ( ) Female Birthday: ________
SS#________________________________
Student Status ( ) FT ( ) PT
( ) Single ( ) Married ( ) Divorced
( ) Separated ( ) Widowed
Home#_____________Pager/Cell # ____
Work# _____________Ext: __________
Driver's License # __________________
Employer:___________________________
( ) FT ( ) PT
Employer
Address:____________________________
____
How long there? ____________________
Occupation__________________________
____
Doctor ______________Dentist ________

2. **Spouse/Parent Information**

His/Her Name _______________________
Relation: ___________________________
Employer: ___________________________
____
Work # ___________________ Ext. _____
SS # _______________________________
Birthday ____________________________
DL # _______________________________

3. **Person Responsible for Account**

His/Her Name _______________________
Relation: ___________________________
SS # _______________________________
Home #: ___________ Work #: ______
BillingAddress:______________________
____

4. **Nearest Relative**

His/Her Name: ______________________
Address: ____________________________
____
Home # ___________ Work: _________

5. **Who can we thank for referring you to our office?**

His/Her Name: ______________________
Home #: ____________________________
( ) Coupon ( ) Newspaper ( ) Other
( ) Advertisement

6. **Insurance Information**

Dental Coverage ( ) Yes ( ) No
Medical Coverage ( ) Yes ( ) No

**** Primary Insurance Information**

Insured's Last Name: ________________
First ______________________________
Address if different than above:
____
____
Insured Birthday ____________________
SS # _______________________________
Relation to Insured ( ) Self ( ) Spouse
( ) Child ( ) Other
Insurance Co: _______________________
Address: ____________________________
____
Insured ID# _________________________
Group # ____________________________
Insured Employer: ___________________
____

****Secondary Insurance Information**

Insured Last Name: __________________
First: _______________________________
Address if different than above: ________
____
Insured Birthday: ____________________
Insured SS# ________________________
Relation to Insured ( ) Self (Spouse
( ) Child ( ) Other
InsuranceCo.________________________
____
Address: ____________________________
____
Insured's ID #: ______________________
Insured's
Employer____________________________

7. Insurance/Payment Agreement

**** I authorize use of this form for all my insurance.
**** I authorize release of information to all of my insurance companies.
**** I authorize my doctor/dentist to act as my agent in helping me obtain payment from my insurance companies.
**** I permit a copy of this authorization to be used in place of the original.
**** If I receive payment directly from my insurance company I agree to pay the dentist in full at time of service.
**** All recommended testing is my responsibility.

**** I am aware that any balance over 30 days may be subject to a service charge of 1 ½ % per month (18 % annually). Any court costs or attorney's fees will be added to the total amount due. I understand that I am responsible for my bill and that insurance claims for services do not alter my responsibility to pay my account within the time allowed by this office's credit policy (90 days). I further agree that this contract will remain in force for all services regardless of the date signed. There may be a $50.00 charge for broken appointments within a 24 hour notice. There may be a $35.00 fee for imposed cheeks returned for any reason.

Signature X ____Date: _____________