O'CONNOR DENTAL CARE

REGISTRATION FORM (Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (select one) ○ Single ○ Mar ○ Div ○ Sep ○ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Email address:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Mailing address:	Social Security no.:	Home phone no.: ( )

Mobile phone no:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Whom may we thank for you referring you?

INSURANCE INFORMATION

(Please give your insurance card and a picture I.D. to the office staff.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary Insurance company:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

I give permission for O'Connor Dental Care to release information regarding my account, appointments, and/or care to the listed individuals:

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize O'Connor Dental Care to release any information required to process my claims. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature *Date*