ALBION FAMILY DENTAL
REGISTRATION FORM

Please print	Today's Date:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Can we text/email appt. information to you? ❑ Yes ❑ No	Email address	Cell phone: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

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

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone: ( )

Whom can we thank for your referral?
Previous Dentist:
Physician:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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

Is this person a patient here? ❑ Yes ❑ No

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

Insurance Company:

Subscriber's name:	Social Security no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

IN CASE OF EMERGENCY

Name of local friend or relative:	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 provider. I understand that I am financially responsible for any balance. I also authorize Albion Family Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*