Patient Registration

18807 Beardslee Blvd., Suite 102
Bothell, WA. 98011
(425) 489-8274

Today's Date: _____

First Name: _____ **MI.:** _____ **Last Name:** _____**Title:** _____

Address: Street _____**Home Phone:** _____

City_____ **State** ____ **Zip** _____ **Work Phone:** _____

E-mail Address: _____@_____ **Cell Phone:** _____

Mailing Address: _____ **Same As Above**

Date Of Birth: _____**Age:**_____ **Sex: M F Social Security No.:** _____

What is your occupation? _____**Are you a student? Y N School:** _____

Have you or a member of your family been a patient of our office before? Y N

Whom/When? _____

Who referred you?_____**Who is your general dentist?**_____

Emergency Contact? Name: _____**Telephone Number:**_____

How may we help you? [reason for your referral to our office]: _____

Who Is Financially Responsible For Your Account?

Name: _____**Relationship:**_____

Address: _____

City:_____**State:**_____**Zip:**_____**Phone:**_____

E-mail Address: _____@_____ **Cell Phone:** _____

Primary Insurance Company:

Dental Medical Both

Name:_____ **Telephone:** _____

Address:_____ **Group Number:** _____

_____

Primary Subscriber:

Name:_____

Address: _____**Social Security No:**_____

_____ **Sex M F Birth Date:** _____

Telephone: _____

Employer: _____**Phone Number:** _____

Patient Relationship To Insured: Self Spouse Child Other: _____

Secondary Insurance Company: Dental Medical Both

Name: _____**Telephone:** _____

Address:_____**Group Number:** _____

_____

Secondary Subscriber:

Name:_____**Telephone:**_____

Address:_____**Social Security No:** _____

_____ **Sex: M F Birth Date:** _____

Employer: _____ **Phone:** _____

Patient Relationship To Insured: Self Spouse Child Other: _____

As A Courtesy To Our Patients:

The office staff will communicate with your insurance company(s) to help verify insurance coverage limits, help you to obtain your maximum benefits, and help provide an estimate based on your insurance plan. Due to the many types of insurance plans and companies that we interact with in both the medical and dental insurance realms, our *estimates* of your coverage may be affected by:

- **Your individual insurance plan's "maximum benefits"**
- **Pre-authorization requirements**
- **Eligibility at the time of service**
- **Any specific plan limitations**
- **Any pending claims being processed**
- **Individual insurance company interpretation of the UCR [usual and customary fees]**
- **Our participation in dental plans that may influence our fees**

In spite of our best attempts to accurately predict your individual coverage, there may be a balance due after your service has been provided. When your insurance is entirely processed, we will notify you of any balance owed [or balance due back to you] to make appropriate payment arrangements. *If you have specific concerns about your insurance coverage, we recommend you personally contact your insurance company for clarification of coverage benefits since the insurance contract you have is between your insurance company and you. When in doubt, you also may obtain a written pre-authorization from your insurance company.*

Assignment Of Benefits And Records Release Authorization:

I hereby authorize my insurance benefits to be paid directly to my surgeon. I am financially responsible for any balances due. I also authorize my surgeon to release any information required for this claim.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. In the event a collection action should be required, I agree to pay the costs of collection including, but not limited to, the collection fees, court costs and reasonable attorney fees.

Signature: _____ **Date:** _____