DILBER S. SRAON, DDS, INC.
& ASSOCIATES
Cosmetic & General Dentistry

# PATIENT REGISTRATION

Date: _____

Full Name: _____ Sex: M F DOB: _____/_____/_____

Address: _____ City, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Driver's License #: _____ State: ____ Exp: _____

Employer/School (If Student): _____ Phone: _____

Nearest Relative Not Living With You: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Whom May We Thank For Referring You To Us: _____

## RESPONSIBLE PARTY

Person Responsible For Account: _____ Relationship: _____

Mailing Address: _____ Phone: _____ DOB: ___/___/___

Driver's License #: _____ Employer: _____ Phone: _____

## INSURANCE INFORMATION

Subscriber Name: _____ DOB: ___/___/___ ID/SSN: _____

Employer: _____ Phone: _____ Group #: _____

Insurance Co: _____ Address: _____ Phone: _____

Relationship to Patient: _____

## SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ DOB: ___/___/___ ID/SSN: _____

Employer: _____ Phone: _____ Group #: _____

Insurance Co: _____ Address: _____ Phone: _____

Relationship to Patient: _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand as a courtesy, this office will help prepare my insurance forms to assist in making collection from insurance companies and will credit such collections to my account. We will do our best to provide an estimate of insurance payment, but cannot render services on the assumption that charges will be paid by the insurance company.
Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Date: _____