

PATIENT REGISTRATION

Today's Date _____ (Please check which phone number(s) we may confirm at.)
Cell Phone _____ Home Phone _____ Work Phone _____

Patient Social Security No. _____ - _____ - _____ E-mail _____

Patient Date of Birth (MM/DD/YYYY) ____/____/____ Male Female

Patient _____

Last Name First Name MI Nickname

Mailing Address _____

If P.O. Box, please list physical address _____

City _____ State _____ Zip Code _____ - _____

Marital Status: Single _____ Married _____ Separated _____ Widowed _____ Divorced _____

Patient Employed By _____ Occupation _____

Business Address _____

Spouse Name _____

Spouse Employed By _____ Occupation _____

Business Address _____ Business Phone _____

If child is under 18, please complete the following:

Dad's Name _____ Employed By _____ Work Phone _____

Mom's Name _____ Employed By _____ Work Phone _____

Who is responsible for this account? Please do not list insurance company name.

Responsible Party Name _____

Responsible Party Social Security Number _____ - _____ - _____

Responsible Party Driver's License/ID Number _____ Expiration Date _____

Responsible Party Date of Birth ____/____/____ (MM/DD/YYYY)

<u>Primary Insurance (Dental only)</u>	<u>Secondary Insurance (Dental only)</u>
Name of Company _____	Name of Company _____
Address _____	Address _____
Phone No. _____	Phone No. _____
Subscriber Name _____	Subscriber Name _____
Subscriber ID: _____	Subscriber ID: _____
Sub. Date of Birth _____	Sub. Date of Birth _____
Group/Plan/Policy # _____	Group/Plan/Policy # _____
Group Name _____	Group Name _____
If on the Oregon Health Plan, provide Recipient ID# _____	If on the Oregon Health Plan, provide Recipient ID# _____

Emergency Contact _____ Phone _____

How did you first hear about Dr. Lester? _____

I certify that the above information is accurate and complete to the best of my knowledge. I will not hold my dentist or staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I am financially responsible for all charges whether or not covered by insurance. If it becomes necessary to effect collections for any amount, the undersigned also agrees to pay for all costs and expenses, including reasonable attorney fees. I assign insurance benefits payable to David A. Lester, DDS, PC (this may be changed on individual claims if paid by patient directly to provider). I hereby authorize Dr. Lester to release information necessary to secure payment of insurance benefits. I also understand the office allows for a broken appointment fee if less than 48-hour reschedule notice.

Signature of Responsible Party _____ **Date** _____