Patient Registration

Patient Information

First Name:_____Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone#:_____ Alt Phone#:_____

Date of Birth:_____ Age: _____ ☐ Please send via e-mail/text mgs

Sex: ☐ Male ☐ Female Parent's Email:_____

Mother's / Guardian Information

First Name:_____Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone#:_____ Alt Phone#:_____

Date of Birth:_____ Social Security #: _____

Father's/ Guardian Information

First Name:_____Last Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone#:_____ Alt Phone#:_____

Date of Birth:_____ Social Security #: _____

Insurance Information

Name of Insured: _____Relationship to Patient:_____

Date of Birth:_____Social Security #_____

Employer:_____Insurance Name:_____

Insurance Phone#_____Policy#_____Group#_____

A certify that I (or my dependent) have insurance coverage as indicated and adding directly to this office all insurance benefits otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Medicaid / Chip

☐ Denta Quest ☐ MCNA ☐ Traditional TMHP Member ID #_____

Responsible Party Signature :_____Date :_____