CHINA TOWNSHIP FAMILY DENTISTRY, P.C.

5013 St. Clair Highway – China Twp., Michigan 48054 – 810.329.6655

PATIENT REGISTRATION INFORMATION

Patient Name____Miss____Mrs.____Mr.____Dr._____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Alternate Contact #_____

D.O.B._____ SS#_____ Check One ____ M____F Age_____

How will you be paying? Please check one _____CASH_____CHECK_____CHARGE

Driver's License #_____EMAIL_____

Patient Employed by_____Occupation_____

City of Employer_____Phone#_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____Phone#_____

Relationship to patient?_____

PRIMARY INSURANCE

Person Responsible for Account_____ Relationship to Patient_____

Subscribers Birthdate_____ Subscribers Contact# or Cell#_____

Address_____City_____ State_____ Zip_____

Person Employed By_____Occupation_____

Employer Location_____City_____Phone#_____

Insurance Company_____ Member ID# (as appears on card)_____

Subscribers SS#_____ Group #_____

SECONDARY INSURANCE

Is patient covered by additional insurance? _____Yes_____No

Subscriber Name_____ Relationship to Patient_____

Subscribers Birthdate_____ Subscribers Contact# or Cell#_____

Address_____ City_____ State_____ Zip_____

Subscriber Employed by_____ City_____Phone#_____

Insurance Company_____Member ID# (as appears on card)_____

Subscribers SS#_____ Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have coverage with_____ and assign China Twp Family Dentistry, P.C. directly to all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby 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.

Responsible Party Signature_____**Date**_____