

5 STAR DENTAL CARE REGISTRATION FORM

(Please Print)

Today's date:				Email:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, legal Guardians name?		Relationship to Patient:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			City:		State/Zip:		
Social Security:		DL#		Home: ()		Cell: ()	
Occupation:		Employer:			Employer phone no.: ()		
Who May We Thank For this Referral (please check one box): <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan							
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to home/work <input type="checkbox"/> News Paper <input type="checkbox"/> Other							
Other family members seen here:							
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance							
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize 5 Star Dental Care or insurance company to release any information required to process my claims.							
Patient/Guardian signature						Date	