PATIENT REGISTRATION FORM

Name_____Mr./Dr./Mrs./Ms./Miss

Address_____City_____State____Zip_____

(If minor) Parent's Full Name_____

Telephone: Home_____Cell _____Work_____

Employer:_____Address_____City_____St____

Patient: Date of Birth___/____/_____Social Security#_____-____-_____

Email Address_____@_____Married___Single___Student___

Spouse's Name_____
First Last Middle

Emergency Contact_____Phone_____

Insurance: Yes___ No ___ We can copy your insurance card

Whom may we thank for your referral_____

RELEASE:

I authorize Dr. Lawrence S. Singer to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my(or my child's) dental health care, advice and treatment provided for the purpose of evaluating and administering claims(electronic or written) for insurance benefits.

I authorize release of any information concerning my(or my child's)health care, advice and treatment to another dentist or physician.

I hereby authorize payment of insurance benefits directly to Dr. Lawrence S. Singer, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill of services. Therefore, I understand I am financially responsible for payments in full of all accounts. If my account becomes delinquent, I will accept full responsibility for all fees incurred by a bank or collection agency.

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature_____Date_____