COMMERCE DENTAL GROUP

Patient Registration Form

Patient Last Name: _____ **First:** _____ **Middle Initial:** _____

How do you wish to be addressed? _____ Date of Birth: _____ Male Female

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

Telephone *(Mobile)*: _____ *(Home)*: _____ *(Work)*: _____

Email: _____ Social Security Number: _____

Insurance Information

Primary Insurance

Subscriber Name: _____

Insurance Company: _____

Subscriber ID: _____

Group #: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Employer Name: _____

Employer Phone: _____

Insurance Company: _____

Secondary Insurance

Subscriber Name: _____

Insurance Company: _____

Subscriber ID: _____

Group #: _____

Date of Birth: _____

Relationship to Subscriber: Self Spouse Child Other

Employer Name: _____

Employer Phone: _____

Insurance Company: _____

Please present your insurance card to be scanned for our records.

Responsible Party *(if minor)*

Last Name: _____ First: _____ Middle Initial: _____

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

Telephone *(Mobile)*: _____ *(Home)*: _____ *(Work)*: _____

Email: _____

Emergency Contact

Last Name: _____ First: _____ Middle Initial: _____

Relationship to Patient: _____ Telephone *(Mobile Home Work)*: _____

Consent

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information regarding my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or Commerce Dental Group and understand that my insurance benefits may pay less than the actual bill for services and that I am fully responsible for any services unpaid or covered by my insurance as well as any account balance.

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

Signature _____ Printed Name: _____
(Responsible party, if under age 18)

Date: _____