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## **Patient Registration**

Welcome to our practice! Thank you for selecting our dental healthcare team. Please fill out this form completely. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help!

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Circle: Home Work Cell  
How did you hear about us? \_\_\_\_\_

If you are a student, name of school/college: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Responsible Party**

Name of person responsible: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Is this person currently a patient in our office? Yes No

## **Insurance Information**

Relationship to Insured: Self Spouse Child  
Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Do you have secondary insurance? Yes No  
Relationship to Insured: Self Spouse Child  
Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

## **Authorization to bill insurance and financial agreement:**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_