REGISTRATION FORM

SOUTHWEST DENTISTRY

PATIENT INFORMATION:

Full Name: _____ Preferred Name: _____

What are your preferred pronouns? ☐ He/Him ☐ She/Her ☐ They/Them

Gender you were born as: ☐ Female ☐ Male

Address: _____ State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____

Job/Place of Work: _____ Job Title: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

How did you hear about us? _____

RESPONSIBLE PARTY:

If the patient listed above, is the responsible party, SKIP to the next section.

Parents/Guardians of minors please fill out.

Full Name: _____

Date of Birth: _____ SSN: _____

Address: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

EMERGENCY CONTACT INFORMATION:

Full Name: _____ Relation: _____

Best Contact Phone Number: _____

DENTAL INSURANCE COVERAGE:

Dental Insurance Company: _____ Employer for Insurance: _____

ID Number on Card: _____ Group Number: _____

If your insurance is through your spouse or parent, please provide their name and date of birth for insurance processing. If you are the main policy holder, SKIP to the next section.

Subscriber/Member Name: _____ Date of Birth: _____

Secondary Insurance? Y ☐ N ☐ If yes, please provide: _____

AUTHORIZATION, CONSENT AND AGREEMENT:

I consent to the diagnostic and dental treatment performed by all doctors at Southwest Dentistry, and to the release of information concerning 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 Southwest Dentistry, and understand I am responsible in full for any services not paid for or covered by my insurance benefits and any account balance. In the event the account is not paid in accordance with the financial arrangements, I agree to pay in-office processing fees. I further agree to pay collections costs and attorney fees if this account is placed in the hands of a collection agency or attorney. I am ready and fully understand the terms. I attest to the accuracy of the information on this page. I have been made aware of the Privacy Practices.

Patient/Guardian Signature: _____ Date: _____