Bradford J. Rhodes, D.M.D.

PATIENT REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Sex: ❑ M ❑ F	If the patient is a minor, give parent's/guardian's name: If patient is a full-time student, give school name:

Street address:	City:	State:	ZIP Code:
E-mail:		Social Security:	Drivers Lic.:

Home phone: ( )	Work phone: ( )	Cell phone: ( )

Emergency Contact: Relationship to Patient:	Home phone: ( )	Work phone: ( )

Referred by (please check one box):		❑ Dr.:	❑ Insurance Plan:
❑ Yellow Pages	❑ Close to home/work	❑ Family/Friend:	❑ Other:

ACCOUNT & INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for account:	Birth date: / /	Address (if different):	Home phone: ( )
Social Security:		Relationship to patient:	
Occupation:	Employer:	Employer address:	Employer phone: ( )

Is this patient covered by insurance?	❑ Yes ❑ No	Insurance Company:

Insured's name:	Insured's S.S.:	Birth date: / /	Group number:	ID number:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Insured's name:	Group number:	Policy number:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

ASSIGNMENT, RELEASE, & SIGNATURE

I, ______________________________ certify that I (or my dependent) have insurance coverage with above named insurance company(ies) and assign directly to Bradford J. Rhodes, D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all cost and expenses, including reasonable attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance submissions.

Responsible party signature:

Relationship:	Date: