

PATIENT REGISTRATION

Welcome to our office. Please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: _____
Male/Female: _____ Date of Birth: _____ Soc. Sec. #: _____ Home Phone: _____
Mailing Address: _____ State: _____ Zip: _____
Residential Address: (if different): _____ State: _____ Zip: _____
Employer/School: _____ State: _____ Zip: _____ Phone: _____
Physician: _____ Referring Dentist: _____

Responsible Party's Information: (Person Accompanying Patient if a minor or disabled)

Relationship to patient: _____ Name: _____ DOB: _____
Phone number _____ Soc. Sec. # _____
Address: _____ State: _____ Zip: _____
Employer: _____ Address/Phone: _____

Dental Insurance Plan: _____ Phone: _____
Address: _____ Group Number: _____
Subscriber name: _____ DOB: _____ SS#: _____
Employer (name, address & telephone): _____
Medical Insurance Plan: _____ Phone: _____
Address: _____ Group Number: _____
Employer (name, address & telephone): _____

I have read and been offered a copy of the Privacy Policies of this office.

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information necessary to process my insurance claims. I assign all medical and /or dental benefits to which I am entitled to Granite State Oral Surgery, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for the entire cost of my/my dependent's treatment charges. I understand that I am responsible for any collections and/or attorney's charges, should a collection procedure be necessary. I have read this information and understand it.

Patient/Legal Guardian: _____ Date: _____



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