ANILKUMAR C. PATEL, B.D.S.

PATIENT REGISTRATION AND MEDICAL HISTORY

Name: _____
Last First MI Title

Address: _____ City _____ State _____ ZIP_____

SSN: _____ DOB: _____ Male__ Female __ Home Phone: _____

Cell Phone: _____ E-mail Address: _____ Work Phone: _____

Employer: _____ Occupation: _____ Employment Status: FT__ PT __ Retired___

Student Status: Full Time___ Part Time ___ Where: _____

Marital Status: ✿ Single ✿ Married ✿ Divorced ✿ Widowed ✿ Separated ✿ Domestic Partner

How did you hear about our office? _____ Referred By: _____

Previous Dentist: _____ Phone: _____ Last Visit: _____

Emergency Contact: _____ Phone: _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____ ***(Please circle preference)***

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Anilkumar Patel 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. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

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CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____