CORVALLIS DENTAL GROUP

Patient Registration

PATIENT INFORMATION

Name Birthdate

Address City State Zip code

Occupation Home Phone Mobile Phone

Email

Preferred method of contact/appointment reminders: ☐ Phone ☐ Text ☐ Email

Spouse or Parent's Guardian's Name

Emergency Contact Relationship Phone

How did you hear about us? (please be specific)

Please present photo I.D. to receptionist

RESPONSIBLE PARTY

Name of person responsible for this account Relationship to patient

Address City State Zip code

Employer Phone Work Phone

Email Birthdate

Is this person currently a patient? ☐ Y ☐ N

PRIMARY DENTAL INSURANCE

Subscriber Name Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID # Group #

Insurance Co. Insurance Phone

Insurance Address City State Zip code

Employer Subscriber Birthdate

Please present insurance card to receptionist

SECONDARY DENTAL INSURANCE

Subscriber Name Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID # Group #

Insurance Co. Insurance Phone

Insurance Address City State Zip code

Employer Subscriber Birthdate

Please present insurance card to receptionist

Authorization and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Corvallis Dental Group 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 authorize the use of my signature on all insurance submissions whether manual or electronic. Corvallis Dental Group may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services.

Signature of patient (or parent/guardian if minor) Print Name of patient (or parent/guardian if minor

Date