Patient Registration

Welcome! The staff of **Rocky Mountain Dental Clinic** thanks you for selecting us as your dental care provider. Our aim is to strive to provide you with the best possible dental care. To help us, please fill out this patient information form. If you have any questions or concerns, please ask our staff for assistance.

Patient Information

Patient_____ Birth Date_____ SSN_____
Mailing Address_____ City & State_____ Zip_____
Physical Address_____ City & State _____ Zip_____
Phone (H) _____ (C) _____ (W) _____
Marital Status: Married_____ Single_____ Child_____ Employer_____
Whom do we call in the event of an Emergency? _____
Phone_____ Relationship to the patient_____
Whom may we thank for referring you? _____

Responsible Party (IF DIFFERENT FROM ABOVE PATIENT INFORMATION)

Person responsible for this account _____ Relationship_____
Birth Date _____ SSN _____
Mailing Address_____ City & State_____ Zip_____
Phone (H) _____(C) _____(W)_____
Employer_____ City & State_____ Zip_____

Insurance Information

Name of Insured Person_____ Relationship_____
Address_____ Phone_____
Birth date_____ SSN_____
Employer_____ City & State_____ Zip_____
Insurance Company_____ ID Number_____ Group Number_____
Insurance Phone_____ Address of Insurance Company_____

If there is a *Secondary* Insurance Company, please complete the following:

Name of Insured Person_____ Relationship_____
Address_____ Phone_____
Birth date_____ SSN_____
Employer_____ City & State_____ Zip_____
Insurance Company_____ ID Number_____ Group Number_____
Insurance Phone_____ Address of Insurance Company_____

I herby authorize and direct payment of the dental benefits otherwise payable to me, directly to Rocky Mountain Dental Clinic, Brandon Sheahan DMD. I am aware that I am responsible for all charges incurred, regardless of insurance.

_____ _____
Patient/Guardian Signature **Date**

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