BONHAM FAMILY DENTISTRY -
Patient Registration Form

Patient Name:_____
I prefer to be called:_____
Male_____ Female_____
Birthdate ___/___/___ Age_____
Single__ Married__ Divorced__ Widowed__
SS#_____
Address:_____
_____
City:_____State_____
Zip Code:_____

Phone

Home:_____
Work:_____Ext:_____
Cell:_____
Email: Address:_____
Emergency Contact:_____

Please Tell Us How You Prefer To Be Contacted

__Email notification
__Text Message
__Automated Phone Call
__ Other (Please Explain):
Employer:_____

Other family members seen by us?

_____

Responsible Party

Person Responsible for account:

_____

Phone Numbers:
Hm#_____
Wk#_____ Ext_____
Cell #_____

MailingAddress:_____
_____
_____

SS#_____
Birthdate:_____
Relationship to patient:_____

Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address: _____
_____
_____
Insurance Co. Phone #:_____
Group # :_____
ID#_____

Policy Holder Information:

Name:_____
Birthdate: __/__/__ SS# _____
Address:_____
_____
_____
Employer:_____

Secondary Dental Insurance

Insurance Co. Name:_____
Insurance Co. Address: _____
_____
_____
Insurance Co. Phone #:_____
Group # :_____
ID#_____

Policy Holders Information:

Name:_____
Birthdate:__/__/__ SS#:_____
Address:_____
_____
_____
Employer:_____

For your convenience, we offer the following methods of payment. Please check the option which you prefer. **Payment is due in full at each appointment.**

__cash __personal check __credit card __care credit (payment plan)

I understand that the information I have given today is correct and it is my responsibility to inform the office of any changes.

I understand that this information is protected by HIPAA law and will only be used in the ways outlined in the Notice of Privacy Practices provided to me.

I understand that **I am responsible** for payment of services provided and that insurance is only a means for me to be assisted in the payment of my bill.

Signature:_____Date:_____

THANK YOU FOR ALLOWING US TO CARE FOR YOUR DENTAL NEEDS!