OAKWOOD SMILES
NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME _____ _____ _____ SEX M F BIRTHDATE _____ AGE _____
First Last MI

Social Security # _____ If Patient is a Minor, give Parent's or Guardian's Name _____

Who May We Thank for Referring You to Our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account _____ _____ _____ Marital Status _____
First Last MI

SS #_____Birthdate _____Driver's License # _____ Relation to Patient _____

Employer _____ Occupation _____ Year's Employed _____

RESIDENCE Street _____ Apt # _____ City _____ State _____ Zip _____

MAILING ADDRESS Street _____ Apt # _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone #_____ EXT _____

Cell Phone # _____ EMAIL Address _____

GETTING TO KNOW YOU

Is another member of your family or relative a patient of our practice? _____

How did you hear about our office? _____

Emergency Contact _____ Relationship _____ Phone #_____

DENTAL INSURANCE (Primary Carrier)

Insurance Co. _____ Group #_____

Insurance Co. Address _____

Policyholder's Name _____ DOB _____

Relationship to Patient _____

Policyholder's Employer _____

Work # _____ SS# _____

Cell # _____ Email _____

DENTAL INSURANCE (Secondary Carrier)

Insurance Co. _____ Group #_____

Insurance Co. Address _____

Policyholder's Name _____ DOB _____

Relationship to Patient _____

Policyholder's Employer _____

Work # _____ SS# _____

Cell # _____ Email _____

Assignment/Release Statement

Your signature is necessary for us to:

1. Process all insurance claims
2. Ensure payment for services provided
3. Release medical information to insurance companies needed for the processing of your claims
4. Release information to other medical and dental providers including laboratories, when necessary, for your treatment.

I hereby authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment. I hereby authorize Oakwood Smiles, PC to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I assign all medical and surgical benefits, including major medical benefits to Oakwood Smiles, PC that would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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.

Patient Full Name: _____
(PRINTED)

Patient Signature: _____ Parent/Legal Guardian Signature: _____
(if patient is a minor child)

Witness: _____

Date Signed: _____