Barnett Family Dentistry
Registration

Date:_____ Last Name:_____ First Name:_____ Middle Initial:_____ Sex: M / F

I prefer to be called:_____ Birth Date:_____ Age:_____ SS#:_____

Home Address:_____ Home Phone:_____

_____ Cell Phone:_____

_____ Work Phone:_____

Email:_____

Employer:_____ Occupation:_____

Spouse

Name:_____ Birth Date:_____ SS#:_____

Employer:_____ Work Phone:_____

Person Responsible For Account:_____

Billing address:_____

_____

_____

Home #:_____ Cell #:_____ Work #:_____

PRIMARY DENTAL INSURANCE

Insurance Company:_____

Group #:_____

Effective Date:_____

Policy Holder's Name:_____

SS#:_____

Birth Date:_____

Address:_____

_____

Relationship to Policy Holder:_____

SECONDARY DENTAL INSURANCE

Insurance Company:_____

Group #:_____

Effective Date:_____

Policy Holder's Name:_____

SS#:_____

Birth Date:_____

Address:_____

_____

Relationship to Policy Holder:_____

Assignment and Release

I attest to the accuracy of information on this page. I assign directly to Barnett Family Dentistry all insurance benefits, if any, otherwise payable to me. I authorize the use of my signature on insurance submissions. Barnett Family Dentistry may use my health care information and may disclose such information to the above-named insurance companies to determine insurance benefits or to obtain payment for services rendered. I understand that my dental insurance may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this, I agree to be responsible for payment of services not paid, in whole or in part by my dental insurance. **In the event that your account is turned over for collections**, **you will be responsible for all collection costs, along with all reasonable attorney and court costs incurred by this office.**

PATIENT/GUARDIAN SIGNATURE: _____ DATE:_____