PATIENT REGISTRATION FORM

Today's Date:______________________ **Ann Arbor Periodontal Specialists

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name:______________________________*First Name:____________________________Middle Initial: ___________

*Address: ____

City: ______________________________ State: ______________________ Zip: __________________

Home Phone #: (_____)_______-_____________ *Social Security #: ______________________________________

*Date of Birth:________________Age: _________ *Sex:_______Marital Status:__________Drivers Lic#: ____________

*Employer Name and Address: ____

____ Work Phone #: (_____)__________-___________

E-mail Address:____Cell Phone #: (______)__________-___________

Emergency Contact Name: ______________________________________ Emerg Phone #: (_______) _________-___________

Please tell us how you heard about us:____________________________Referred by________________________________

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse_____ Parent______ Other _________________________

*Last Name:______________________________*First Name:______________________________Middle Initial: ___________

*Address: ____

City: ______________________________ State: ______________________ Zip: __________________

Home Phone #: (_______)____________-__________________ *Social Security #: ________________________________

*Date of Birth:____________________Age: ______________________ *Sex: Female_______Male __________

*Employer Name and Address: ____

____ Work Phone #: (_____)________-__________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name :______________________________________ *Insured's Name: ________________________________

Insured's Social Security #: ____________________________ *Insured's Date of Birth: ___________________________

*Policy / ID #:______________________________*Group #:_______________________Eff Date: __________________

Claims Address & Phone: ____

SECONDARY INSURANCE:

Plan Name : ____ *Insured's Name: ________________________________

*Insured's Social Security #:___________________________ *Insured's Date of Birth: ___________________________

*Policy / ID #:______________________________*Group #:_______________________* Eff Date: __________________

Claims Address & Phone: ____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ____ Date of Birth: ______________

First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Ann Arbor Periodontal Specialists for services rendered to my dependents or me by Dr. Wm. P. Sorensen or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Ann Arbor Periodontal Specialists is unable to collect from my insurance carrier for whatever reason.

DENTAL INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under my dental plan is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Ann Arbor Periodontal Specialists my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Ann Arbor Periodontal Specialists Patient Information Privacy Policy. I hereby authorize Ann Arbor Periodontal Specialists to release any of my or my dependent's dental or incidental non- public personal information that may be necessary for dental evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Ann Arbor Periodontal Specialists to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Ann Arbor Periodontal Specialists to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my dental care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as recommended by Dr. Wm. P. Sorensen.

PATIENT SIGNATURE:____________________________________DATE: ________________

GUARANTOR SIGNATURE: ________________________________ DATE: ________________
(If different from patient)

GUARANTOR NAME (Please Print):

____