PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME___________________________FIRST NAME_________________________M.I.________

STREET ADDRESS____

CITY_________________________________STATE______________________ZIP___________________

HOME PHONE_______________________BIRTHDATE_______________ MARITAL STATUS: S / M

CELL PHONE________________________EMAIL____

NEAREST RELATIVE____PHONE(____)________________

EMERGENCY CONTACT_______________________________________PHONE(____)________________

WHOM MAY WE THANK FOR REFERRING YOU TO US_______________________________________

INSURANCE INFORMATION-PRIMARY	**SECONDARY INFORMATION**
POLICY HOLDER _________________________	POLICYHOLDER_________________________
EMPLOYER NAME________________________	EMPLOYER NAME _______________________
INSURANCE CO.__________________________	INSURANCE CO. _________________________
INS. CO. PHONE # ________________________	INS. CO. PHONE# ________________________
WORK PHONE ___________________________	WORK PHONE ____________________________

FIRST NAME	**LAST NAME**	**SEX**	**DATE OF BIRTH**	**SOCIAL SECURITY**
HEAD OF HOUSEHOLD				
SPOUSE				
CHILDREN				

I AUTHORIZE AZ DENTAL HEALTH INC. TO USE THE DENTAL RECORDS FOR THE ABOVE NAMEDINDIVIDUAL FOR INSURANCE PURPOSES SPECIALISTS CONSULTATIONS AND REFERRALS AS HE DEEMS NECESSARY. BY SIGNING THIS FORM, CONSENT FOR TREATMENT IS GIVEN FOR THE ABOVE NAMED PERSON. *I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR.PICO AND IF MY INSURANCE DECIDES THEM TO BE NONCOVERED FOR ANY REASON I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES.*

PATIENT SIGNATURE____DATE________________