

Ann G. Borgström DDS, PC
Whole Health Dentistry

Form 1: Patient Registration

Name	
Address	City/State/Zip
Home phone	Work phone
Cell phone	Email address
Birth date	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Person to call in case of emergency	Phone
Person responsible for account	Phone
Address	City/State/Zip
Patient's place of employment and address	
Spouse's name	Spouse's work phone
Spouse's place of employment and address	
Name(s) and age(s) of dependent(s)	

If patient is a child:

Parent's name
Father's place of employment, work phone and work address
Mother's place of employment, work phone and work address

<i>Payment is due at time of service. Please indicate preferred method:</i>		<input type="checkbox"/> <i>Cash</i>	<input type="checkbox"/> <i>Check/Debit</i>
<input type="checkbox"/> <i>MasterCard</i>	<input type="checkbox"/> <i>Visa</i>	<input type="checkbox"/> <i>Discover</i>	<input type="checkbox"/> <i>American Express</i>

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Do you have dental insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insured's name	Insured's date of birth	
Name, address and phone of insurance company		
Insurance contract number (if none, then insured's Social Security number)	Group number	
Are you covered under a spouse's or secondary dental plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name, address and phone of secondary insurance company		
Secondary insurance contract number (or insured's Social Security number)	Group number	
Whom can we thank for referring you to our office?		

I authorize Ann G. Borgström DDS, PC, to provide any insurance company(s), claim administrator(s) and consulting health care professionals information concerning health care, advice, medication, treatment or other services provided to me. This information will be used to evaluate and administer claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is sooner.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of patient or authorized person	Date
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I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are true or to leave out facts I know are important (NYS Insurance Law 38, 176 Reg. No. 95).

Signature of patient or authorized person	Date
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If authorizations to pay third party benefits are indicated on this form:

Appropriate authorizations to pay signed by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determination as to the release of dental and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The provider agrees to hold harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid authorization to pay benefits to the provider was made.