Rosenwald & Associates
Cosmetic, Restorative and Preventive Dentistry

Registration Form

TODAY'S DATE _____

PATIENT NAME _____
First Last Initial

ADDRESS _____ APT#_____

CITY _____ STATE _____ZIP_____

WHAT DO YOU PREFER WE CALL YOU?_____

MALE / FEMALE *(Circle One)* DATE OF BIRTH _____
mm/dd/yy

Single Married Separated Divorced Widowed Minor *(Circle One)*

HOME PHONE_____ WORK PHONE _____
CELL PHONE _____ E-MAIL _____

PATIENT'S EMPLOYER _____
EMPLOYER PHONE #_____
PRESENT POSITION_____ HOW LONG? _____
BUSINESS STREET ADDRESS _____
CITY _____ STATE _____ZIP_____

SPOUSE/PARENT NAME _____
EMPLOYER_____
PRESENT POSITION_____ HOW LONG? _____
HOME PHONE_____ WORK PHONE _____
CELL PHONE _____ E-MAIL _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____
OTHER FAMILY MEMBERS IN THIS PRACTICE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PATIENT/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN AN EMERGENCY WHO DOES NOT LIVE WITH YOU
NAME _____
HOME_____ WORK _____ CELL _____

IF CHILD, PARENT OR
GUARDIAN NAME _____
First Last Initial

DENTAL INSURANCE - PRIMARY

EMPLOYEE'S NAME _____
EMPLOYEE'S DATE OF BIRTH_____
EMPLOYER_____ #YRS. _____
NAME OF INSURANCE CO. _____
ADDRESS _____
CITY _____ STATE_____ZIP_____
TELEPHONE_____
GROUP # _____
UNION LOCAL OR GROUP_____
EMPLOYEE SS# _____
MEMBER ID# _____

DENTAL INSURANCE - SECOND

EMPLOYEE'S NAME _____
EMPLOYEE'S DATE OF BIRTH_____
EMPLOYER_____ #YRS._____
NAME OF INSURANCE CO. _____
ADDRESS _____
CITY _____ STATE_____ZIP_____
TELEPHONE_____
GROUP # _____
UNION LOCAL OR GROUP_____
EMPLOYEE SS# _____
MEMBER ID# _____

AUTHORIZATION & RELEASE: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or physician. I hereby authorize payment of insurance benefits directly to the dentist. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual charges for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payer.

FINANCIAL DISCLOSURE: The Truth in Lending Law enacted in 1969 serves to inform borrowers and installment purchasers of the true Annual Interest charged. Balances 90 days past due are subject to a finance charge of 1.5% per month (18% per year). I acknowledge that if default in payment results in this account being turned over for collection, I will be responsible for the full fee PLUS collection fees, legal fees and any other accumulated fees.

Patient's or Guardian's Signature _____ **Date** _____

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