

**ATLANTA LASER DENTISTRY
PATIENT REGISTRATION**

PATIENT

First Name _____ Middle I. _____ Last Name _____

Circle one: Mr. Mrs. Ms. Dr. Other: _____ Name by which you prefer to be called _____

Patient is: Policy Holder _____, Responsible Party _____, Responsible party is also the policy holder for the patient _____

If you are the responsible party and you are not the patient, please fill out this next section:

First Name _____ Last Name _____

Address 1 _____ Address 2 _____

City, State, Zip: _____

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Birth Date _____ Social Security # _____ Driver's Lic. # _____

PATIENT INFORMATION

Home Addr. _____ Work Addr. _____

City, St., Zip _____ City, St., Zip _____

Sex: Male _____ Female _____ **Marital Status:** Circle One: Single Married Divorced Separated Widowed

Home Phone _____ Work Phone _____ Ext. _____ Cell _____

Age: _____ Birth date: _____ Social Security # _____ Driver's Lic. # _____

E-mail address _____ I would like to receive correspondence via e-mail: Yes _____ No _____

Please be assured that we will not disclose your e-mail address to anyone!

How did you hear about our office? _____

Whom may we thank for referring you? _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relation to patient: Self _____ Spouse _____ Child _____ Other _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Employer: _____ Insurance Co. _____

Address 1 _____ Address 1 _____

Address 2 _____ Address 2 _____

City, St, Zip _____ City, St., Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relation to patient: Self _____ Spouse _____ Child _____ Other _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Employer: _____ Insurance Co. _____

Address 1 _____ Address 1 _____

Address 2 _____ Address 2 _____

City, St, Zip _____ City, St., Zip _____

I, the undersigned, have insurance with _____ and assign directly to Atlanta Laser Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that my insurance contract is between me and my insurance company and that I am financially responsible for all charges, whether or not paid by my insurance. I also understand you will provide me with a "best guess" as to what my insurance company will pay, and that it is not a guarantee of actual payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature _____