Welcome

REGISTRATION FORM

Section I: Patient Information Date_____

Name:_____I Prefer to be called:_____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____Work Phone_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____

Email Address_____

Section II Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____Relationship to Patient: _____

Address:_____

City:_____State:_____ Zip:_____Phone: (____)_____

Employer_____ Work Phone (____)_____SSN#_____

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient_____

SSN#:_____ Name of Employer:_____Work Phone: ( )_____

Address of Employer:_____City_____State:_____Zip_____

Insurance Company_____ Grp #_____ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____Work Phone: ( )_____

Address of employer:_____City_____State:_____Zip_____

Your portion of the bill is due on the day of service. Even with dual insurance, you might owe a portion. For any unpaid balance over 90 days, there is a 1 ½ finance charge, regardless of insurance. Please read and sign the following: I authorize dental treatment to be rendered by the dentist and/or staff and I will assume financial responsibility.

Signature_____ Date: _____

I hereby assign all dental benefits to which I am entitled to Tatyana Vilderman DDS, Inc. DBA Eden Dental Center. This assignment will remain in effect until **revoked by me in writing.** I authorize Tatyana Vilderman DDS, Inc. DBA Eden Dental Center to bill my insurance & to release any dental or medical information to my insurance carrier for purposes of claims administration.

Signature:_____ Date:_____