TomsRiver
FAMILY DENTAL GROUP

PATIENT REGISTRATION

DATE: _____

PATIENT NAME LAST	☐ MALE FIRST ☐ FEMALE	DATE OF BIRTH PATIENT SSN/ALT ID
ADDRESS	CITY	STATE ZIP
HOME PHONE ( )	WORK PHONE ( )	
CELL PHONE ( )	E-MAIL ADDRESS	

Best method of reaching you _____

If patient is a dependent, complete the following:

☐ Yes ☐ No Is patient covered by dental insurance?

☐ Yes ☐ No Is patient a dependent according to IRS standards? ☐ Yes ☐ No Is the patient disabled?

☐ Yes ☐ No Does patient attend college FT? Name and location of college _____

(Pick method of payment)

Payment: ☐ Cash ☐ Check ☐ Credit ☐ Debit

Driver's License #_____

Referred by:

☐ Friend ☐ Union ☐ Newspaper ☐ Flyer ☐ Insurance Co. ☐ Website ☐ Other _____

PERSON TO CONTACT IN CASE OF EMERGENCY	PHONE

INSURANCE INFORMATION (must be completed in full)

Please note that if you have any other dental insurance plans you must use both plans to coordinate benefits. The information provided will determine which carrier is the primary and which is secondary.

	PRIMARY	SECONDARY
Name of Insured		
Address		
Phone Number	( )	( )
Date of Birth		
Social Security Number/Alt Id		
Employer Name		
Employer Phone	( )	( )
Dental Insurance (Family, Individual)		
Group Number/I.D. Number		
Medical Insurance Carrier		
Union Name/Local Number		
Are you Hourly or Salary?		

To the best of my knowledge, the information provided is accurate. In the event that there are any changes in my current insurance plans, I will provide that information to Eastern Dental®. I understand that failure to provide such information may cause delays in processing or payment of my claims and I agree to pay if they are not paid timely as a result of such failure.

Signature: _____ Date: _____

NOTIFICATION OF RESPONSIBILITY & SIGNATURE AUTHORIZATIONS

I agree to make payments as services are rendered. I understand that if for any reason my dental insurance does not make expected payment or if my insurance is terminated, I will be responsible for the TOTAL FEE.

I hereby authorize Eastern Dental® to execute in my name all payment application forms for treatment. The determination of treatment rendered by Eastern Dental® shall be conclusive.

Signed _____ Date _____

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Recall Information

Receptionist _____

Account Number: _____ Date: _____

Patient's Name: _____

1. Change of Name: _____
2. Change of Address: _____
3. New Phone Number: (Home)_____(Cell)_____(Work)_____
4. Completed Change in Computer: _____

Employment and Insurance Change

Insured: _____ D.O.B. _____

New Employer: _____

Address: _____

New Insurance Company: _____ Effective Date: _____

I.D./Group Number: _____

Insured's Social Security Number: _____

Terminated Insurance: _____

Secondary Insurance

Insured: _____ D.O.B. _____

Employer: _____

Address: _____

Insurance Company: _____ Effective Date: _____

Insured's Social Security Number: _____

Family Members Covered: All ( )

1. _____
2. _____
3. _____
4. _____
5. _____