REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	◯ Mr. ◯ Mrs.	◯ Miss ◯ Ms.	Marital status (select one) ◯ Single ◯ Mar ◯ Div ◯ Sep ◯ Wid
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	
Street address:	Social Security no.:	Home Phone No.: ( )			
P.O. box:	City:	State:	ZIP Code:		
Employer Phone No.: ( )	Employer:	Cell Phone No: ( )			
Chose office because/Referred to office by (please check one box):	◯ Dr.	◯ Insurance Plan	◯ Hospital		
◯ Family	◯ Friend	◯ Close to home/work	◯ Yellow Pages	◯ Other	
Other family members seen here:	Email Address:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ◯ Yes ◯ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ◯ Yes ◯ No			
Please indicate primary insurance:			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber:	◯ Self	◯ Spouse	◯ Child	◯ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Horizon One Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*