Patient Registration Form

GENERAL INFORMATION

Patient Name _____ Social Security #_____
First Last Initial

Address _____ Phone# _____

City _____ State _____ Zip _____

SEX M ☐ F ☐ Race _____ Age _____ Date of Birth_____ _____ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Email address _____

Responsible Party Name_____ Employed By _____

Business Name _____ Business Phone _____

Business Address _____

Monthly Income _____ Number of Dependents _____

SOURCE OF INCOME: AFDC: $_____ SSI: $_____ PENSION: $_____CHILD SUPPORT: $_____ SOC SEC: $_____ SELF EMPLOYMENT: $ _____ UNEMPLOYMENT: $ _____

Do you need help with translation? Yes ☐ No ☐ Do you have any physical disabilities? Yes ☐ No ☐

YOUR LEVEL OF EDUCATION: ☐High school not completed ☐High School Diploma ☐College Education

Emergency Contact Name: _____ Phone #:_____

Relationship to patient _____

Other person's authorized to bring your child to the doctor _____

PRIMARY INSURANCE

Medicare # _____ Medicaid # _____

Insurance Company _____

Contract # _____ Group #_____ Subscriber # _____

Name of Insured_____ Employed By _____
First Last

Relation to Patient_____ Initial Birthday _____ Soc. Sec # _____

Address (If different from patient's) _____
Phone _____ **(**Cell ☐ Home ☐ Other ☐**)**

City _____ State _____ Zip _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that all the information provided is accurate. I understand that I am financially responsible for any and all charges not covered by insurance of the program in which I qualify for. I hereby authorize The Smile Connection at Bond Community Health Center to release any information to collect payment of benefits. I authorize the use of this signature on all payment and insurance submissions.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**