Welcome

PATIENT REGISTRATION

Ryan Rush DDS PLLC

Patient Name

_____

Last First Middle Initial

Preferred Name _____

Today's Date_____

Address

_____Apt#_____

City_____ State_____ Zip_____

Home Phone _____

Cell Phone_____

Email_____

Date of Birth: _____

Social Security #: _____

Single ( ) Married ( ) Separated ( ) Divorced ( )
Widowed ( ) Minor ( )

Employer_____

(Parent Employer if minor)

Work Address_____

_____

Work Phone_____

Spouse/Parent Name_____

Spouse Employed By_____

Responsible Party_____

Address (if different from above)

_____

_____

Other Family Members in this Practice

_____

Emergency Contact

Name: _____Phone:_____

Whom may we thank for this referral?

_____

DENTAL INSURANCE (Primary)

Insured

Name_____ DOB_____

Social Security# or Member ID# _____

Employer Name_____

Insurance Company_____

Claims Address_____

_____

Insurance Telephone_____

Policy or Group#_____

DENTAL INSURANCE (Secondary if applicable)

Insured

Name_____ DOB_____

Social Security# or Member ID# _____

Employer Name_____

Insurance Company_____

Claims Address_____

_____

Insurance Telephone_____

Policy or Group#_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

PATIENT/GUARDIAN SIGNATURE

_____