Westborough Dental Associates **Registration** **PT. ID# _____**

Patient Information:

First Name: _____ MI: _____Last Name: _____ Preferred: _____

Address: _____City: _____State: _____ Zip: _____

Date of Birth: _____ SS #: _____ Sex: ◯ Female ◯ Male

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Domestic Partner

E-Mail Address: _____ ◯ I would like to receive correspondences via e-mail.

Check preferred contact number:

◯ Home: _____ ◯ Work: _____Ext:_____ ◯ Cell:_____

Student Status: ◯ Full Time ◯ Part Time School Name: _____ City & State: _____

Emergency Contact Person: _____ Relationship to Patient: _____ Phone #: _____

◯ **Not Covered by Dental Insurance – Self Pay**

Insurance Information: (If patient is the insurance policy holder, duplicate information fields may be skipped)

Primary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Secondary Dental Insurance Company: _____ Subscriber's Employer: _____

Subscriber of Insurance: _____ DOB of Subscriber: _____ Relationship to Patient: _____

Subscriber SS #: _____ Alternate ID #: _____ Group #: _____

Referrals: We would love to know how you were referred to us: ◯ Westborough Dental Associates Website ◯ Insurance Company/Website ◯ Phonebook ◯ Mailer/Postcard ◯ Driving By/Window ◯ Patient or Provider:_____

Acknowledgements:

Insurance Assignment & Release: I certify that I and/or my dependents have insurance coverage as specified above and assign Westborough Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. Westborough Dental Associates may use and disclose my health information to the above named insurances and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Receipt of Notice of Privacy Practices: I certify that I have been provided a copy of this office's Notice of Privacy Practices. (Separate Printout)

I, _____, have provided accurate information to the best of my ability.

Print Patient Name

_____ _____

Signature of Patient/Guardian **Date**