Robert C Todd DMD
Patient Registration Form

Dental Insurance Primary Coverage

Employee Name ______________________________

Employee Date of Birth ______________________________

Employee Social Security Number ______________________________

Employer ______________________________

Employer's Address ______________________________

Employer's Phone No. ______________________________

Name of Insurance Company ______________________________

Insurance Co. Address ______________________________

Policy Number ______________________________

Group Name ______________________________

Payor ID# ______________________________

Dental Insurance Secondary Coverage

Employee Name ______________________________

Employee Date of Birth ______________________________

Employer ______________________________

Employer's Address ______________________________

Employer's Phone No. ______________________________

Name of Insurance Company ______________________________

Insurance Co. Address ______________________________

Insurance Co. Phone Number ______________________________

Policy Number ______________________________

Group Name ______________________________

Payor ID# ______________________________

We will complete and file all insurance claims for your reimbursement. We will also file insurance claims for secondary coverage.

Insured Signature ______________________________

Robert C Todd DMD
Patient Registration Form

Today's Date ________________________________ Date of Birth _________________________________

Patient's Name ____

Spouse's Name ____

If Child, Parent's Name____

Name you prefer to be called ____

Residence Address:

Street ____

City____State_______________Zip________________

Business Address:

Street ____

City____State_______________Zip________________

Telephone:

Residence_____________________________________Business ______________________________

Best Time to Call ____

May we call you at work? YES/NO If yes, best time is ______________________________________

Cell Phone NO.____

E-Mail Address ____

Who is responsible for payment of this account?____

Method of Payment: Cash Check Credit Card

If you would like us to process your dental insurance for your reimbursement, Please complete the back of this form.

Other family members who have been treated at our office: ______________________________________

Whom may we thank for this referral?____

Someone to notify in case of emergency: Name ____

Phone No.____

Consent for dental treatment:

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) health care and treatment provided, for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care and treatment to another dentist. I understand that I am responsible for all costs of dental treatment. I authorize use of my dental photographs for publication or educational purposes.

Patient Signature (or Guardian if under 18) ____