**Dr. Joshua Rowley, DMD**

**PATIENT REGISTRATION FORM**

|  |  |
| --- | --- |
| Patient’s last name: First: Middle:  | Birthdate: |
| SS# | Street address: |
| P.O. Box: | City: | State: | ZIP code: |
| Cell phone # :( ) - | Home phone # :( ) - | Work phone # :( ) - |
| Marital status:  | Spouse’s name: | Email: |
| List other family members with same contact information: |

 Do you want to receive an **email** for an appointment reminder?

 Do you want to receive a **text message** for an appointment reminder?

 Both

**DENTAL INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Primary insurance co.: | Phone number: |
| Mailing address: |
| Subscriber name: | Relationship to subscriber: |
| Subscriber employer: | Subscriber Birthdate: |
| Subscriber SS # : | Group # : | ID # : |

|  |  |
| --- | --- |
| Secondary insurance co. (if applicable): | Phone number: |
| Mailing address: |
| Subscriber name: | Relationship to subscriber: |
| Subscriber employer: | Subscriber Birthdate: |
| Subscriber SS # : | Group # : | ID # : |

I authorize release of any information relating to dental work performed in this office and to release any information required to process my claims. I also authorize payment of all group insurance benefits to be made payable directly to Joshua Rowley, DMD. I understand that I am responsible for all costs of dental treatment and agree to pay for them in full, at or before completion unless other arrangements are made with the office manager.

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 Patient/Guardian Signature Date