**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