REGISTRATION FORM

HYATT FAMILY DENTAL

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Preferred Name:	SSN:	Birth date: / /	Age:	Sex:

Street address:	City:	State/Zip

Home #	Cell #	Email:

Occupation:	Employer:	Employer phone no.: ( )

How did you learn about Hyatt Family Dental? (please check one) ❑ Insurance Plan ❑ Drive by ❑ Family ❑ Friend ❑ Google Search ❑ 800-Dentist ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's SSN.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize registration form or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*