WSU-AEGD DENTAL CLINIC

REGISTRATION FORM

Today's Date:	**How did you hear about our clinic?**

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status: (please circle) Single○ Married○ Divorced○ Widowed○

Address:	City, State, and Zip code:	Birth date:	Age:	Sex: ○ M ○ F

Is patient responsible party? ○ Yes ○ No

Social Security no.:	Home phone no.:	Work phone no.:	Cell phone no.: □ Check if you would like to receive text reminders
Employer:	Employer address:		Employer phone no.:

Email: _____ ○ I would like to receive email correspondences

Person responsible for bill (Relationship to patient):	Birth date:	Address (if different):	Home/Cell phone no.:
Employment Status: O Full Time O Part Time O Retired	Employer:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Relationship to Patient:

Please notify us if you have secondary insurance:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/Cell 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 WSU-AEGD Dental Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date