# TAWAS FAMILY DENTAL CARE PATIENT REGISTRATION

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:**

## PATIENT INFORMATION:

Legal Name:_____Date_____
Preferred name (nickname) _____
Birthdate: _____Social security #:_____
Driver's License or State ID #:_____
Male/Female? Marital Status: _____ email:_____
Permanent Address _____
_____
Home phone #: _____Cell phone #:_____
Summer/cottage address:_____
Employer's name and address: _____
_____
Employer's phone#: _____ Extension #_____

How did you hear of our office:_____
If a student, school attended: _____ full/part time

## SPOUSES INFORMATION:

Name: _____
Spouse's birthdate: _____
Address, (if different):_____
Home phone, (if different):_____Cell#:_____
Employer's name and address:_____
_____
Employer's phone #:_____ Extension # _____

## INSURANCE INFORMATION:

**PRIMARY** insurance company _____Phone #_____
Group #_____Member ID #: _____
Name of the member holding the insurance: _____

**SECONDARY** insurance company_____Phone #_____
Group #_____Member ID #:_____
Name of the member holding the insurance:_____DOB_____

## EMERGENCY INFORMATION:

**EMERGENCY CONTACT**: Name: _____ phone: _____
Relationship to patient: _____

Name and phone number of closest relative not living with you:
_____

**PERSON FINANCIALLY RESPONSIBLE**, if different from patient:

Name: _____Birthdate:_____
Social Security #:_____Email:_____
Address: _____
Home phone #: _____ Cell Phone #: _____
Employer's name & address:_____
_____
Employer's phone #:_____ Extension #_____

## PLEASE TURN OVER AND COMPLETE

## IF PATIENT IS A CHILD:

**MOTHER's Name:** _____ Marital status _____
Mother's birthdate: _____Social Security #_____
Address, if different from child's: _____
_____
Home phone #: _____Cell #: _____ email:_____
Employer's name and address: _____
_____
Employer's phone #_____ Extension #:_____

**FATHER's Name:** _____Marital status _____
Father's birthdate: _____ Social Security # _____
Address, if different from patient's: _____
_____
Home phone #: _____ Cell #: _____ email:_____
Employer's name and address: _____
_____
Employer's phone # _____Extension #:_____

## GUARDIAN INFORMATION, IF APPLICABLE:

Name: _____Marital Status_____
Guardian's birthdate: _____ Social Security #_____
Address:_____
_____
Home phone #: _____ Cell #: _____ email:_____
Employer's name and address:_____
_____
Employer's phone #: _____ Extension: _____
If covered by guardian's insurance, subscriber name:_____
Insurance company:_____ Phone #_____
Insurance group #_____ Member ID #_____

**The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I, or my dependent is entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.**

**By signing below I acknowledge the following: 1) I assign directly to Tawas Family Dental Care/Charles Kudwa, D.D.S., all insurance benefits, if any, otherwise payable to me for services rendered. 2) I am responsible for any and all payments or co-payments for services rendered; 3) Any claims submitted to insurance, which are subsequently declined shall become my responsibility; 4) In the event my owed balance should become delinquent, I acknowledge I may additionally become responsible for additional fees including but not limited to: late fees, collection fees, interest of 1.5%, court costs and attorney fees. Payment is due at the time of service unless other arrangements have been made.**

**Also by signing below, I request and authorize the dental staff to perform necessary dental services, including the use of anesthetics, that embodies certain risks, for myself or my child which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.**

**Patient's signature**_____

**Parent/Guardian's signature if patient is a child:** _____