PATIENT REGISTRATION

Today's Date______________ *(Please check which phone number(s) we may confirm at.)*

Cell Phone _____________**Home Phone** ___________**Work Phone** ___________

Patient Social Security No.______-____-______ E-mail__________________________

Patient Date of Birth (MM/DD/YYYY) ____/____/______ Male ☐ Female ☐

Patient____

Last Name First Name MI Nickname

Mailing Address____

If P.O. Box, please list physical address_____________________________________

City__________________ State__________________ Zip Code_________-________

Marital Status: Single____ Married____ Separated____ Widowed____ Divorced___

Patient Employed By____________________________ Occupation_______________

Business Address____

Spouse Name____

Spouse Employed By______________________________Occupation_______________

Business Address___________________________ Business Phone_________________

If child is under 18, please complete the following:

Dad's Name______________ Employed By__________________Work Phone________

Mom's Name_____________ Employed By__________________Work Phone________

Who is responsible for this account? **Please do not list insurance company name.**

Responsible Party Name____

Responsible Party Social Security Number________-_____-________

Responsible Party Driver's License/ID Number ____________ Expiration Date________

Responsible Party Date of Birth ____/_____/______(MM/DD/YYYY)

Primary Insurance (Dental only)	**Secondary Insurance (Dental only)**
Name of Company__________________	Name of Company_________________
Address____________________________	Address____________________________
____________________________________	____________________________________
Phone No. ______________________	Phone No.________________________
Subscriber Name___________________	Subscriber Name____________________
Subscriber ID: ____________________	Subscriber ID: _____________________
Sub. Date of Birth _________________	Sub. Date of Birth__________________
Group/Plan/Policy #________________	Group/Plan/Policy #________________
Group Name_______________________	Group Name________________________
If on the Oregon Health Plan, provide Recipient ID#______________	If on the Oregon Health Plan, provide Recipient ID#_______________

Emergency Contact ________________________ Phone _________________________

How did you first hear about Dr. Lester?____

I certify that the above information is accurate and complete to the best of my knowledge. I will not hold my dentist or staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I am financially responsible for all charges whether or not covered by insurance. If it becomes necessary to effect collections for any amount, the undersigned also agrees to pay for all costs and expenses, including reasonable attorney fees. I assign insurance benefits payable to David A. Lester, DDS, PC (this may be changed on individual claims if paid by patient directly to provider). I hereby authorize Dr. Lester to release information necessary to secure payment of insurance benefits. I also understand the office allows for a broken appointment fee if less than 48-hour reschedule notice.

Signature of Responsible Party______________________________**Date**__________