

Suncook Dental
Adult Patient Registration

Please read, complete and sign all portions of this Registration Form. The information you provide on this form is confidential and will NOT be released to anyone without your prior written consent. Thank you.

Full Name _____ S.S.N: _____
Address _____
City _____ State _____ ZIP _____
Date of Birth _____ Circle one: Male Female
Marital Status: Single Married Divorced Other
Patient Contacts: Cell Phone _____ Work Phone _____ Home Phone _____
Email Address _____
Your Employer _____ Spouse's Name _____

Who is responsible for this account? _____ Relationship: Spouse Parent Other
How will you settle your account? Cash Check Credit/Debit Card

For new patients, how were you referred to our office? Please circle.

Sign Phonebook Website Patient _____

Primary Insured's Full Name _____ Primary Insured's SSN _____
Primary Insured's Date of Birth _____
Primary Insured's Employer _____
Primary Insured's Insurance Company _____ Group Number _____

Secondary Insured's Full Name _____ Primary Insured's SSN _____
Secondary Insured's Date of Birth _____
Secondary Insured's Employer _____
Secondary Insured's Insurance Company _____ Group Number _____

As a courtesy and convenience to you, our office will submit charges for dental services to your insurance carrier. However, the patient is primarily responsible for the financial charges, in other words, the services provided by any dentist or hygienist amounts to an agreement between the patient and this office. The insurance relationship constitutes an agreement between the carrier and the patient.

Please remember that insurance benefits are determined by the type of plan chosen by your employer. We urge you to read your policy so you are fully aware of any limitations of the benefits provided. Of course, we will do whatever we can to see that you receive maximum benefits within the structure of your particular group dental plan.

If there are any questions regarding your account, please call. Many times a phone call will prevent a misunderstanding.

Patient Insurance Consent

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to Suncook Dental. This form also authorizes Suncook Dental to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "Signature on File". I authorize Suncook Dental to release treatment records or any information deemed pertinent to my insurance carrier as necessary and / or requested.

Patient Signature _____ Date _____