PATIENT REGISTRATION FORM

Logan Peak Dental

PATIENT INFORMATION

Patient is: ☐ Resp. Party ☐ Child (Under 18)
First Name _____
Last Name _____
Email Address _____
Address _____
City _____ State/Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Current Patient? ☐ Yes ☐ No
Sex: ☐ Male ☐ Female
Birth Date _____ Age _____
Marital Status: ☐ Single ☐ Married ☐ Divorced
Social Security Number _____
Employer _____
Employer Address _____
Emergency Contact _____
Relation _____ Phone _____

Who can we thank for your referral? (Check any that apply)
☐ Cache Valley Classifieds ☐ Cache Valley Direct
☐ Phone Book ☐ Insurance Provider List ☐ Radio
☐ Online Search ☐ Location/Walk In ☐ Home Town Values
☐ Social Media ☐ Other _____
☐ Current Patient Referral _____

RESPONSIBLE PARTY

(Guardian of patient, if patient is under 18 Years Old)

First Name _____
Last Name _____
Home Phone _____
Email Address _____
Address _____
City _____ State/Zip _____
Work Phone _____
Cell Phone _____
Sex: ☐ Male ☐ Female
Birth Date _____ Age _____
Marital Status: ☐ Single ☐ Married ☐ Divorced
Social Security Number _____
Drivers License Number/State _____
Employer _____
Employer Address _____

PRIMARY INSURANCE INFORMATION

Primary Insurance _____
Employer _____
Address of Insurance Company _____
Customer Service Phone _____
Name of Insured _____
DOB of Insured _____
Subscriber ID # (may be SSN) _____
Relationship to patient _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance _____
Employer _____
Address _____
Customer Service Phone _____
Name of Insured _____
DOB of Insured _____
Subscriber ID # (may be SSN) _____
Relationship to patient _____

AUTHORIZATION

I authorize my insurance company to pay to Logan Peak Dental all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submission. I authorize Logan Peak Dental to release all information necessary to secure payment of benefits. I understand that Logan Peak Dental cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill collection action will be taken and I will be responsible for paying any collection and attorney fees.

Signature _____

Date _____

LOGAN PEAK DENTAL
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