PATIENT REGISTRATION FORM

PATIENT NAME:_____ RESPONSIBLE PARTY NAME_____

ADDRESS:_____ CITY, STATE, ZIP:_____

PERMANENT ADDRESS:._____ CITY, STATE, ZIP:_____

HOME NUMBER:( )_____BUSINESS NUMBER:( )_____CELL:( )_____

DATE OF BIRTH:_____ AGE:_____ **PATIENT** SOCIAL SECURITY#:_____

EMAIL ADDRESS:_____

PHARMACY:_____ PHARMACY PHONE:_____

PHARMACY ADDRESS:_____

IF INJURY IS JOB RELATED TO AN ACCIDENT, was it an: Auto Accident or a Job Related Injury? _____

DATE OF INJURY:_____ SEX: ☐ MALE ☐ FEMALE

REFERRING DOCTOR NAME & PHONE #:_____

IS PATIENT: ☐ EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-STUDENT ☐ RETIRED

IS PATIENT: ☐ SINGLE ☐ MARRIED ☐ OTHER_____

PATIENT'S EMPLOYER / SCHOOL NAME & ADDRESS:_____

RESPONSIBLE PARTY'S SOCIAL SECURITY#:_____RELATIONSHIP TO PATIENT:_____

RESPONSIBLE PARTY'S EMPLOYER NAME / ADDRESS:_____

SPOUSE OR NEAREST RELATIVE NAME / PHONE / ADDRESS:_____

SPOUSE OR NEAREST RELATIVE NAME / PHONE / ADDRESS:_____

WHAT ARE YOU BEING SEEN FOR:_____FIRST DATE OF SYMPTOMS:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE
INSURANCE CO NAME:_____

INS. CO. ADDRESS: _____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

POLICY NO.:_____GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

SECONDARY INSURANCE
INSURANCE CO NAME:_____

INS. CO. ADDRESS:_____

POLICY HOLDER NAME:_____

RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

POLICY NO.: _____GROUP NO.:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of [redacted], Enrique G.Wismann, D.M.D., 8877 W. Union Hills Dr., Suite 600, Peoria, AZ 85382 for the dental benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize [redacted], Enrique G. Wismann, D.M.D., to release any information required in the course of my examination or treatment. Also, I acknowledge that if I have dental insurance coverage, my dental insurance may include a provision for billing other sources of payment for my total bill.

PATIENT SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN:_____ DATE:_____

PATIENT INFORMATION