Registration Form - Ahern, Nichols, Ahern, Hersey & Butterfield Family Dentistry

Patient Name:_____ Date of Birth:_____ SS#:_____

Address:_____ Home T#:_____ Cell T#:_____

Employer:_____ Work T#:_____ Email:_____

Marital Status:_____ Spouse's Name:_____ Date of Birth:_____ SS#_____

Address:_____ Home T#:_____

Employer:_____ Cell#:_____

Emergency Contact:_____ T#_____ Whom may we thank for referring you: _____

Person Financially Responsible for Account:

Name:_____ Date of Birth:_____ SS#:_____

Address: _____Home T#:_____

Employer:_____ Work T#:_____

Relationship to Patient:_____Email:_____ Cell T#:_____

Dental Insurance Information:

Primary Insurance:_____Group#:_____T#:_____

Insurance Address:_____ Relationship to Patient:_____

Insured Name:_____ Date of Birth:_____ ID#:_____

Employer Name and Address:_____

Secondary Insurance:_____Group#:_____T#:_____

Insurance Address:_____Relationship to Patient:_____

Insured Name:_____ Date of Birth:_____ ID#:_____

Employer Name and Address:_____

Family Members:

Name:_____ Date of Birth:_____ T#:_____Resides w/_____

Name:_____ Date of Birth:_____ T#:_____Resides w/_____

Name:_____ Date of Birth:_____ T#:_____ Resides w/_____

Name:_____ Date of Birth:_____ T#:_____ Resides w/_____

Name:_____ Date of Birth:_____ T#:_____ Resides w/_____

Assignment & Release: I understand that claims for dental services rendered may be submitted to my insurance carrier by the above named providers. I authorize payment directly to the above named group of dental providers, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized release of any information relating to dental claims to my insurance company. Ahern, Nichols, Ahern, Hersey & Butterfield Family Dentistry may communicate with other members on your account regarding scheduling and treatment.

Signature:_____ **Print Name**:_____ **Date**:_____