Sonja L Maggard, DMD
Family, Cosmetic, & Implant Dentistry

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Registration Form

PATIENT INFORMATION: (Please print)

Today's Date:____/____/_____

Name _____
Last First Initial

Nickname_____ Birthdate____/____/_____ SS#_____
(Please provide for insurance/identification purposes)

Whom may we thank for referring you? _____

Male____ Female____

Please circle one: Married Divorced Single Widowed

Address_____ City_____ State_____Zip_____
Cell Phone_____Home Phone_____ Work Phone _____
Email Address_____ Occupation _____
Employer_____ Employer Phone _____
Employer Address_____City_____ State_____Zip_____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name_____ Relationship to Patient _____
Address_____ City_____ State_____Zip_____
Contact Number _____

INSURANCE INFORMATION:

Insur. Co. Name_____ Phone_____
Address _____
Subscriber's Name_____ Relationship to Patient_____
(If other than patient, please complete – if same as patient, write "same as above")
Subscriber's SS#_____ Birthdate____/____/_____
ID# on Card _____
Employer/Group Name_____ Group #_____
Employer Address_____City_____ State_____Zip_____

I verify that the information completed above is accurate, and I understand that I am responsible for my account regardless of my insurance. I also understand that my insurance reflects only an agreement between my and my insurance company. Any balance remaining after insurance is the responsibility of the patient or guarantor. I understand that I may be charged a 1.5% finance charge per month for any delinquent balances on the account. I give my permission for the dentist and/or clinical team to take any necessary radiographs, study models and/or photographs in order to make a complete diagnosis of my dental needs. I authorize the dentist to release records as needed to my insurance company or third party to secure payment of benefits. I authorize my dental carrier to send payments directly to the dentist. Lastly, I authorize use of this signature on all insurance submissions.

Patient/Guardian Signature:_____ Date:____/____/_____

Doctor Signature:_____ Date:____/____/_____