PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient Is: ☐ Policy Holder

☐ Responsible Party

RESPONSIBLE PARTY (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

PATIENT INFORMATION

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Child

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail Address: _____ ☐ I would like to receive correspondences via e-mail

Student Status: ◯ Full Time ◯ Part Time

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member ID# _____

Employer: _____
Address: _____
City, State, Zip: _____

Insurance Company: _____
Address: _____
City, State, Zip: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____ Member ID# _____

Employer: _____
Address: _____
City, State, Zip: _____

Insurance Company: _____
Address: _____
City, State, Zip: _____

Laurie Jayne Toomajanian, DDS

As a service to you, we will be happy to take care of your dental insurance claim processing for you. You must, however, provide us with accurate information needed to complete the request for payment.

Due to the many federally required changes in insurance policies, it is no longer an easy task to interpret each of the thousands of individual policies. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you to check with your insurance company for information about your coverage. It is *your* insurance and *your* responsibility to know your coverage. The policy is between *you* and *your* insurance company, and not between the insurance company and the doctor. Different insurance companies, even different group policies within the same insurance company, will reduce coverage amounts for some procedures. *For example: this office uses the "white" resin fillings to restore our patients' cavities. The insurance company may reduce the coverage to a "silver" amalgam filling amount of their own choosing, making you responsible for any difference. For further information, please consult your policy.* Your insurance coverage is not determined by your dental needs – but by how much your employer contributes to the plan. If you are not satisfied with the coverage of your policy, please contact your employer's Human Resources department.

We will exhaust all possibilities to try to help you use your insurance benefits. However, if we are unsuccessful receiving payment within 3 months from your insurance company, we will find it necessary to bill you and give you responsibility to pursue the matter with your insurance company. We will gladly provide you with the appropriate form including specific information regarding your treatment.

In recent months, since the federal HIPAA activation, insurance companies have become more and more difficult for us to work with. They are, however, more willing to discuss with, you, the patient, your own treatment and requests for the payment of that treatment.

We thank you for your understanding in this matter.

Consent: I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Signature: Date: