

Patrick S. Burchfield, D.D.S., P.C.

Today's Date _____

PATIENT REGISTRATION

Please fill in the information below for the patient being seen today.

Patient Name: _____
Last First Middle Initial

Please indicate the name you wish to go by _____

Please Indicate _____ Mr. _____ Mrs. _____ Ms. _____ Doctor

Please indicate: Male Female Please Indicate: Married Single Child Other: _____

Date of birth _____ Social Security No. _____ Drivers License _____

Mailing Address: Street _____ Apt No. _____

City _____ State _____ Zip Code _____

Telephone Numbers Home _____ Work _____ Ext _____

Fax _____ Pager _____ E-mail _____

Patient's Employer: _____ Address _____

City _____ State _____ Zip _____

Nearest Relative/Friend not living with you _____ Telephone _____

Spouse's Name _____ Work _____

Medical Alerts – Please complete the attached form so that we are aware of any medical conditions that you have.

Primary Dental Insurance _____
Please provide a copy of your card for verification and pre-authorization purposes.

Patient/Guarantor Employer Information – INSURED PERSON

Name _____ Relationship to patient _____

Employer Name _____ Telephone _____

Address: _____ City _____ State _____ Zip _____

Social Security No. _____ Date of Birth _____

Whom may we thank for referring you to our office? _____

____ Dental Office ____ Yellow Pages ____ Newspaper ____ School ____ Work ____ Other: _____

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to Patrick S. Burchfield, D.D.S., P.C. otherwise payable to me for services rendered. I authorize this provider or any of his representatives to release information concerning my findings, diagnosis or treatment to the insurance company. I also authorize the insurance company to release any information concerning the status of my claims to this provider and his representatives.

Patient Signature/Guarantor

Date