

FREMONT FAMILY DENTISTRY
4464 Fremont Avenue North, Suite 103
Seattle, WA 98103
206-267-7300

PATIENT REGISTRATION

Name:

(Last)	(First)	(Middle)	Date of Birth	Sex	Marital Status M P S W	Social Security Number
Patient Address - Street		City	State	Zip		Patient Home Phone
Patients Employer				Patient Cell Phone		Patient Work Phone
Spouse, Partner or Legal Guardian's Name			Date of Birth		Social Security Number	
Spouse/Partner Address - Street		City	State	Zip		Spouse Home Phone
Spouse/Partner Employer				Spouse Cell Phone		Spouse Work Phone
Dental Primary Insurance - Name		I.D. Number	Group Number		Subscriber	
Dental Secondary Insurance - Name		I.D. Number	Group Number		Subscriber	
In case of Emergency Notify - Name			Home Phone		Work Phone	

FINANCIAL RESPONSIBILITY POLICY

1. We are happy to submit a statement of services rendered to your insurance carrier for each visit.
2. Even though an insurance claim may be pending, you are fully responsible for your account. We cannot accept the responsibility for collecting any insurance claim, negotiating a settlement or disputed claim, or a third party claim.
3. You are responsible for the payment of your account. Should your account be referred for collection, the undersigned shall pay all reasonable collection expenses.

ACCOUNT AND INSURANCE BENEFITS ACCEPTANCE SIGNATURE

_____ **Patient or Responsible Party**

_____ **Date**