Welcome to Frehner Family Dental

Daniel Frehner DDS
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REGISTRATION FORM

Section I: **Patient Information** **Date_______________**

Name:____ Prefer to be called: _________________________

Address:____City:________________State:__________Zip____________

Home Phone (______) _______________ Work Phone (_____) ______________ Cell Phone (___) ____________________

Email Address____ Would you like to correspond by e-mail? ☐ Yes ☐ No

Place of Employment _______________________________ Spouse place of Employment__________________________

The best time to contact me is: ☐ A.M. ☐ P.M. ☐ Lunch hour _________ on my ☐ Home ☐ Work ☐ Cell phone

Date of Birth: ______________________ Drivers License # _____________________________________ State ________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School:________________________________ City/State___________________________ ☐ FT ☐ PT

Spouse/ Parent's Name: _________________________________Spouse/parent contact number (___) _________________

Whom may we thank for referring you?____

Person to contact in case of emergency____________________________________ phone (___)______________________

Section II **Dental Insurance Information**

Name of Policy Holder____________________________ DOB_______________ ☐ Self ☐ Spouse ☐ Parent ☐ Other

SSN#:_________________________ Name of Employer: ______________________ Work Phone: (____) _________________

Address of Employer:_____________________________________City____________________State:______Zip ____________

Insurance Company________________________________ Group #_________________ ID#___________________________

Ins Co Address:____ Ins Co. phone:________________________________

----------- DO YOU HAVE ANY SECONDARY INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Policy Holder____________________________ DOB_______________ ☐ Self ☐ Spouse ☐ Parent ☐ Other

SSN#:__________________________ Name of Employer: _____________________ Work Phone: (____) _________________

Address of Employer:___________________________________City____________________State:_________Zip ____________

Insurance Company________________________________ Grp #____________________ ID#___________________________

Ins Co Address:____ Ins Co.phone:________________________________

Section III **Responsible Party Information**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Policy Holder ☐ Other (Complete if other than self or policy holder)

Name: ____

Address: ____ Phone: (___) ______________________

City______________________________________ State: _____ Zip ____________

Employer ____ Work Phone (___)______________________

Section IV **Release & Assignment**

I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. In case of Divorce or Separation, responsible party remains the same unless the divorce decree requires the other parent to pay all or part of the treatment costs. It is the authorizing parent's responsibility to collect from the other parent.

Signature of Patient/Parent/Guardian ____ Date __________________