PATIENT REGISTRATION

Patient Information:

First Name: ____________________ Last Name: ____________________ Middle Initial: ______

Preferred Name or Nickname: ____________________

Patient's Address: ____

City: ____________________ State: ____________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone ________________ Extension #: __________ Sex: Female Male

Height: __________ Weight: __________ Marital Status: ____________

Birth date: ____________________ Social Security #: ____________________

E-mail: __________________________

Referred By (Dentist): ____________________

INSURANCE INFORMATION

☐ *I Do Not Have Any Dental Insurance*

******If you do not have dental insurance please skip this section******

- Policy Holder (main name on the policy): ____________________
- Date of Birth of the Policy Holder: ____________________
- Name of the Insurance Company: ____________________
- Policy Group Number: ____________________
- Employer for Insurance: ____________________
- Subscriber ID/Member ID Number: ____________________
- Relationship to the Policy Holder if not you: ____________________

I authorize Dr. Gavin Aaron, D.D.S., M.S. or the practice to release any information in the course of my exam or treatment to my insurance company. Also, authorize payment directly to Dr. Gavin Aaron, D.D.S., M.S. or the practice for services rendered. **Any amount not paid by my insurance company is my full financial responsibility.**

Signature: ______________________________ Date: ____________________