

Registration Form

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is kept completely confidential.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DOB _____ GENDER _____ S.S. NUMBER _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (if different than above) _____

E-MAIL ADDRESS _____ CONFIRMATION TEXT : YES or NO

EMPLOYER _____ WORK PHONE _____

IF MARRIED, WHAT IS YOUR SPOUSE'S NAME? _____

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S S.S NUMBER _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK NUMBER _____

ARE YOU EXPERIENCING ANY DENTAL PROBLEMS AT THIS TIME? IF SO, WHAT? _____

HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL VISIT? _____

WHAT WAS DONE THEN? _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE DENTAL INSURANCE? _____

To obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following information:

INSURANCE CARRIER _____

GROUP # _____ SUBSCRIBER ID _____ PHONE _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER OF SUBSCRIBER _____

I hereby authorize and request the performance of dental services for myself by the staff of Rodney G. Sigua, DDS, MAGD, PLLC.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by our staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

Signature

Date