ANDREW GODZYK D.M.D. • ORTHODONTICS

PLEASE PRINT LEGIBLY

ACCOUNT REGISTRATION

Date _____

CONFIDENTIAL PATIENT INFORMATION

Patient _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

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

CONFIDENTIAL REPONSIBLE PARTY INFORMATION

Mother _____ (Last) _____ (First) _____ (Middle) Marital Status _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Phone: Home _____ Work _____ **Email** _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Father _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone: Home _____ Work _____ **Email** _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Other _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Residence _____ (Street) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone: Home _____ Work _____ Cell _____ **Email** _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Policy Holder's Name _____ Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? **If Yes:** Name _____ Soc. Sec. # _____

Secondary Insurance _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

X _____ Authorized Signature of Covered Person/Employee *Date*

X _____ Authorized Signature of Covered Person/Employee *Date*

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X _____ **Authorized Signature of Covered Person/Employee** ***Date***

X _____ Authorized Signature of Covered Person/Employee ***Date***

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to client: _____

Please sign and return to receptionist.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure

Signature _____ Date _____