GODZYK ORTHODONTICS

PLEASE PRINT LEGIBLY **ACCOUNT REGISTRATION** Date_____

Patient _____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
Phone # (_____)_____-_____ D. O B. _____/_____/_____ Social Security #_____
Please choose one Mobile Home Work
Whom may we thank for referring you to our office?_____
Whom can we share treatment information with_____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Mother _____ Marital Status_____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
How long at this address? _____ D. O B. _____/_____/_____
Phone #'s: Mobile/Home (_____)_____-_____ Work (_____)_____-_____
Email: _____ Social Security #_____
Employer _____ Occupation _____ Number of Years Employed _____
Whom can we share Financial matters with_____

Father _____ Marital Status_____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
How long at this address? _____ D. O B. _____/_____/_____
Phone #'s: Mobile/Home (_____)_____-_____ Work (_____)_____-_____
Email: _____ Social Security #_____
Employer _____ Occupation _____ Number of Years Employed _____
Whom can we share Financial matters with_____

Other _____ Marital Status_____
(Last) (First) (Middle)
Address _____
(Street) (City) (State) (Zip)
How long at this address? _____ D. O B. _____/_____/_____
Phone #'s: Mobile/Home (_____)_____-_____ Work (_____)_____-_____
Email: _____ Social Security #_____
Employer _____ Occupation _____ Number of Years Employed _____
Whom can we share Financial matters with_____

INSURANCE INFORMATION

Policy Holder's Name: _____ D.O.B. _____/_____/_____ Soc. Sec. #_____
Insurance Company _____ State:_____ ID # _____ Group # _____
Insurance Co. Phone + (_____)_____-_____ Policy Holder Employer_____

Secondary Insurance

Policy Holder's Name: _____ D.O.B. _____/_____/_____ Soc. Sec. #_____
Insurance Company _____ State:_____ ID # _____ Group # _____
Insurance Co. Phone + (_____)_____-_____ Policy Holder 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 signatures 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 _____ | **X** _____
Authorized signature of covered Person/Employee Date | 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 _____ | **X** _____
Authorized signature of covered Person/Employee Date | Authorized signature of covered Person/Employee Date

EMERGENCY INFORMATION

Name of nearest relative not living with you_____
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 payment of benefits for services rendered and to facilitate the processing of insurance claims on my behalf.

Signature_____Date _____