PIEDMONT
ORAL & FACIAL SURGERY
Jay J. Patel, DMD

Patient Registration Form

Patient Name: SSN: Birthdate:
Address: Sex: M / F
Home Phone: Cell Phone: Email:
Employer Name:
Physician Name:
Referred by:

Person responsible for bill (Complete only if different from patient)

Guarantor Name: SSN:
Relationship to Patient: Birthdate:
Address: Phone Number:
Employer Name: Employer Phone Number:
Employer Address:

Emergency Contact:

Name: Relationship:
Address:
Home Phone: Work Phone:

Primary Insurance

Plan Name: I.D. Number: Group Number:
Address:
Policy Holder: Effective Date:
Policy Holder's SSN:
Policy Holder's DOB:

Secondary Insurance

Plan Name: I.D. Number: Group Number:
Address:
Policy Holder: Effective Date:
Policy Holder's SSN:
Policy Holder's DOB:

I authorize the release of any medical information necessary to process this bill to my insurance company. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _______________________________________ Date: __________________________

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