PERRY SILVA D.D.S., M.D.

REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date: / /	Age:		Sex: ❑ M ❑ F		
Street address:	Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:		Employer phone no.: ( )		
Referred to office by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Other					
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is the patient covered by insurance? ❑ Yes ❑ No			
Please indicate primary insurance ❑ Anthem/Dental Blue ❑ United Concordia ❑ Metlife ❑ 1st Dental Health ❑ Private Pay ❑ Anthem/Prudent Buyer ❑ Other (Please specify)			

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize treatment and agree to pay all fees and charges for such treatment. I understand that I am financially responsible for any balance. I authorize Perry Silva D.D.S., M.D. or insurance company to release any information required to process my claims. If needed, I authorize the use of this statement to obtain credit information. I have received a copy of the HIPAA Notice of Privacy Practices (dated 07/25/13).

_____ _____

Patient/Guardian signature *Date*