PATIENT REGISTRATION FORM

TAWZER DENTAL

First Name: _____ Last Name: _____ Patient Is: ☐ Responsible Party ☐ Child

Address: _____ City: _____ State/Zip: _____

Who can we thank for your referral? (Check any that apply)

☐ Phone Book ☐ Insurance Provider List ☐ Online Search ☐ Location/Walk In ☐ Other _____

Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____ A Current Patient _____

Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Social Security Number: _____ Employer: _____ Address: _____

Email: _____ Emergency Contact: _____ Relation: _____ Phone: _____

RESPONSIBLE PARTY (If patient above is a Child or Spouse, Please fill out info below)

First Name: _____ Last Name: _____ Home Phone: ( ) _____

Address: _____ City: _____ State/Zip: _____

Work Phone: ( ) _____ Cell Phone: ( ) _____

Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Social Security Number: _____ Employer: _____ Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

*Employer: _____

Address: _____

Customer Service Phone: _____

Name of Insured: _____ DOB of Insured: _____

Subscriber ID # (can be SSN) : _____

*Group # _____

Relationship to patient: _____

Secondary Insurance: _____

*Employer: _____

Address: _____

Customer Service Phone: _____

Name of Insured: _____ DOB of Insured: _____

Subscriber ID # (can be SSN) : _____

*Group # _____

Relationship to patient: _____

AUTHORIZATION

I authorize my insurance company to pay to Jarron Tawzer all insurance benefits otherwise payable to me for series rendered. I authorize the use of this signature on all insurance submission. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Jarron Tawzer cannot render services on the assumption that any of the charges will be paid by an insurance company. I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill collection action will be taken and I will be responsible for paying any collection and attorney fees.

Signature: _____ Date: _____

JARRON T. TAWZER D.M.D.

150 East 200 North, Ste. F Logan, UT 84321 Tel: 1.435.753.1686 Fax: 1.435.750.6736