SpringRockDental

Patient Registration Form

Date:

SpringRock Dental requests this information for the purposes of providing a complete and comprehensive oral health examination. No one outside of SpringRock Dental will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in SpringRock Dental being unable to accept you as a patient.

Patient Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev.	Last Name:	First Name:	Middle Name:
Gender: ☐ Male ☐ Female ☐ Transgender	Date of Birth:	Social Security #:	Kaiser HRN:
Street Address:			
City:	State:	Zip Code:	
Email:	Home Phone:	Cell Phone:	Work Phone:
Please contact me by: ☐ Phone ☐ Email ☐ Text Preferred Contact #: ☐ Cell ☐ Home ☐ Work		Occupation:	
Why did you choose this clinic? (Please choose one option.) ☐ KP Physician referral ☐ KP member e-blast ☐ ACP Advertising ☐ Word of Mouth ☐ Other Explain:			

Dental Insurance Information

Please give your dental insurance card to the receptionist.

Person Responsible for Bill:	Address:	Home Phone:	Date of Birth:
Is this person a patient here? ☐ Yes ☐ No	Is this patient covered by insurance? ☐ Yes ☐ No	Occupation:	Employer:
Employer Phone:	Employer Address: City: State: Zip Code:		
Primary Insurance:	Other Insurance:		
Subscriber's Name:		Subscriber's S.S. #:	Date of Birth:
Patient's relationship to the subscriber:		Group #:	Policy #:
Secondary Insurance (if applicable):	Subscriber's Name: Patient's Relationship to Subscriber:	Group #:	Policy #:

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Emergency Contact Information

Name of Local Friend/Relative:	Relationship to Patient:	Home Phone:	Work or Cell Phone:

Patient Demographic Information

The following **optional** information is collected to better track the demographics of our patient population.

Ethnicity:	Language Preferences :	Family Size:	Income level:
☐ White/Caucasian ☐ Asian ☐ Hispanic ☐ Black/African American ☐ Other	☐ English ☐ Spanish ☐ Other	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+	☐ Less than $30,000 ☐ $30,000–$41,000 ☐ $41,000–$52,000 ☐ $52,000–$63,000 ☐ $63,000–$74,000 ☐ $74,000+

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to SpringRock Dental. I understand that I am financially responsible for any balance. I also authorize SpringRock Dental or insurance company to release any information required to process my claims.

Patient/Parent/Guardian Signature: _____ Date: _____