Dr. Pienkowski DDS
FAMILY DENTISTRY

Patient Registration

Today's Date _____/_____/20_____ (Please Print)

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	How should we address you?	Birth Date / /	Age	Sex ❑M ❑ F

Street Address	Social Security No.	Home Phone No. ( )

City	State	ZIP Code	Years at this address	E-mail Address

Occupation	Employer	Years with this employer	Employer Phone No. ( )

Who may we thank for referring you? ❑ Friend _____ ❑ Family _____
❑ Newspaper _____ ❑ Radio ❑ Sign ❑ Yellow Pages ❑ Dr. _____ ❑ Other _____

Other Family Members Seen Here_____

ACCOUNT AND INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Person responsible for services ❑ Self ❑_____	Birth Date / /	Street Address
Is this person a patient here? ❑ Yes ❑ No	Home Phone No. ( )	City State ZIP Code

Occupation	Employer	Employer Address	City	State	ZIP Code	Employer Phone No. ( )

Is this person covered by dental insurance? ❑ Yes ❑ No	Insurance Company	Subscriber S. S. No.	Group No.	Policy No.	Deductible $
Primary Policy Holder's Name	Insurance Phone No. ( )	Insurance Address	City	State	ZIP Code

Patient's Relationship to Primary Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Is this person covered by a second dental insurance? ❑ Yes ❑ No	Insurance Company	Subscriber S. S. No.	Group No.	Policy No.	Deductible $
Secondary Policy Holder's Name	Insurance Phone No. ( )	Insurance Address	City	State	ZIP Code

Patient's Relationship to Secondary Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

All the information on this form is true to the best of my knowledge. I hereby authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits to which I am entitled. I understand that payment is due at the time of services. I agree to pay for any balances that are not paid for by my insurance policy 30 days after services have been rendered to me. I agree that any balances which exceed 30 days from the date of service may be subject to a 1.5% monthly finance charge (18% annually). In the event of default, I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees, an additional 50% of the balance added for collection costs, and any other costs that will be required to effect collection of this account. I understand that failing to pay my balances to Dr. Pienkowski is a sufficient reason for dismissal as a patient of record.

Signature of Patient / Parent / Guardian	Signature of Account Holder
Signature of Primary Insurance Holder	Signature of Secondary Insurance Holder

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )