

SOUTH PARK ORTHODONTICS

Paul A. DiFranco, DDS

Patient Registration – Please **PRINT**

Home Phone # _____ Cell Phone # _____

Patient's _____ Patient's _____

Last Name _____ First Name _____

Address _____

City – State – Zip _____ Date of Birth _____

Primary Insurance Information

Primary Carrier _____ Phone # _____

Claims Address _____

Group # _____ Policy # _____

Guarantor Name _____ Social Security # _____ Guarantor Birthdate _____

Relationship to Patient Self ___ Spouse ___ Parent ___ Other ___ Employer Name _____

Secondary Insurance Information

Secondary Carrier _____ Phone # _____

Claims Address _____

Group # _____ Policy # _____

Guarantor Name _____ Social Security # _____ Guarantor Birthdate _____

Relationship to Patient Self ___ Spouse ___ Parent ___ Other ___ Employer Name _____

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD FOR A COPY

Written Disclosure

The doctor and/or staff of South Park Orthodontics have my permission to leave messages regarding my treatment, appointments and/or financial information on my answering machine.

Signature of Patient or Parent (If patient is under 18) _____ Date _____

Release of Information

I fully understand that I am solely responsible for my account balance regardless of delays or nonpayment by my insurance company. I hereby authorize **RELEASE OF ALL DENTAL/MEDICAL RECORDS NECESSARY** to my insurance company, in order that they may process and pay for any claims.

Signature of Patient or Parent (If patient is under 18) _____ Date _____

Sign below if you wish benefits to be paid directly to the dentist

I Authorize payment of dental benefits directly to the provider of services.

Signature of Patient or Parent (If patient is under 18) _____ Date _____