205 West Hwy 95 PO Box 420 Parma, ID 83660
www.trailridgefamilydental.com
e-mail: trailridgefamilydental@hotmail.com

PATIENT REGISTRATION

Name:____ Preferred Name:___________________________________

Address:____

Home Phone:_______________________________________ Work Phone:______________________________________

Cell Phone:____ Email:____

How would you prefer to be contacted? ❑Home ❑Cell ❑Work ❑Text ❑Email

Social Security Number:_____________________________ Date of Birth:___________________________________

Employer:____ Occupation:_____________________________________

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Gender: ❑Male ❑Female

Spouse's name:____

Spouse's Employer:___________________________________ Occupation:_____________________________________

Emergency Contact: Name:_________________________ Phone:_____________________ Relationship:___________________

If patient is a minor, please give the parent or guardian's name:____

Who is responsible for this account?____

How did you hear about our office? ❑Patient Referral (Patient's Name)_______________________ ❑Other________________

INSURANCE INFORMATION

Subscribers Name:___________________________________ Relationship to Patient:______________________________

Subscriber ID:______________________________________ Subscriber Birth Date:_________________________________

Insurance Co:_______________________________________ Group#:____

Is patient covered by additional insurance? ❑Yes ❑No

Subscribers Name:___________________________________ Relationship to Patient:______________________________

Subscriber ID:______________________________________ Subscriber Birth Date:_________________________________

Insurance Co:______________________________________ Group#:____

ASSIGNMENT AND RELEASE

I certify that I (or my Dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:____ Date:__________________________