E.A. HAWSE HEALTH CENTER
REGISTRATION FORM
Dental

(Please Print)

Today's Date:	**NEW:**	**UPDATED:**

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single☐ Mar☐ Div☐ Sep☐ Wid☐

Is this your legal name: ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: ☐ M ☐F

Street address:	Social Security No:	Home phone no: ( )

P.O. Box:	City:	State:	County:	Zip Code:

Occupation:	Employer:	Employer phone no: ( )

Race: W ☐ B ☐ Am Indian ☐ Hispanic ☐ Other☐	Referred by: Family ☐ Friend ☐ Close to home/work ☐ Yellow Pg ☐ Other ☐

Are you a Veteran? ___Yes ___No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐Yes ☐No Social Security Number: _____

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐Yes ☐No

Please indicate primary insurance	☐ Medicare	☐ Acordia Chips	☐ Acordia PEIA	☐ Aetna	☐ BC/BS
☐ Benefit Assistance	☐ Boilermaker	☐ Southern Health	☐Medicaid/UniSys	☐National Telephone	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth Date:	Group no:	ID no:	Co-Payment: $

Subscriber's Address:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

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: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize E. A. Hawse Health Center or insurance company to release any information required to process my claims. I authorize E. A. Hawse Health Center to perform any necessary treatments of diagnostic tests for Medical or Dental services.
HIGH MEDIUM LOW

_____ _____

Patient/Guardian Signature *Date*