Seattle Periodontics and Implant Dentistry
720 Olive Way, Suite 810, Seattle WA. 98101
206-628-0404 | office@ePeriodontist.com

PATIENT REGISTRATION

Patient's Name *(Please Print)*

(Last) *(First)* *(Middle)*	Date of Birth / /	Sex	Marital Status M P S W	**Social Security Number** (for insurance purposes) - -
Patient's Address – Street *City* *State* *Zip*				Patient Home Phone
Patient's Employer		Patient Cell Phone		Patient Work Phone
Spouse, Partner or Legal Guardian's Name *(Last)* *(First)* *(Middle)*			Date of Birth / /	**Social Security Number** (for insurance policy holder) - -
Spouse/Partner Address –*Street* *City* *State* *Zip*				Spouse Home Phone
Spouse/Partner Employer		Spouse Cell Phone		Spouse Work Phone

Dental Primary Insurance – Name	I.D. Number	Group Number	Subscriber
Dental Secondary Insurance – Name	I.D. Number	Group Number	Subscriber
Medical Insurance – Name	I.D. Number	Group Number	Subscriber
In Case of Emergency Notify – Name	Cell Phone	Work Phone	
Patient E-mail Address (may be used to for office communication and/or confirming appointments).			
Office Communication: Do you want to want to receive texts regarding your appointments? **Yes** or **No**			

FINANCIAL RESPONSIBILITY POLICY

1. We are happy to submit a statement of services rendered, to your insurance carrier for each visit.
2. Even though an insurance claim may be pending, you are fully responsible for your account. We cannot accept the responsibility for collecting any insurance claim, negotiating a settlement or a disputed claim, or a third party claim.
3. You are responsible for the payment of your account. Should your account be referred for collection, the undersigned shall pay all reasonable collection expenses.

Account and Insurance Benefits Acceptance Signature

Patient or Responsible Party: _____ Date: _____
Signature