

PIEDMONT

ORAL & FACIAL SURGERY

Jay J Patel, DMD

Patient Registration Form

Patient Name:	SSN:	Birthdate:
Address:		Sex: M / F
Home Phone: 1»	Cell Phone:	
Email:		
Employer Name:		
Physician Name:		
Referred by:		

Person responsible for bill (Complete only if different from patient)

Guarantor Name:	SSN:
Relationship to Patient:	Birthdate:
Address:	Phone Number:
Employer Name:	Employer Phone Number:
Employer Address:	

Emergency Contact:

Name:	Relationship:
Address:	
Home Phone:	Work Phone:

Primary Insurance

Plan Name:	I.D. Number:	Group Number:
Address:		
Policy Holder:		Effective Date:
Policy Holder's SSN:		
Policy Holder's DOB:		

Secondary Insurance

Plan Name:	I.D. Number:	Group Number:
Address:		
Policy Holder:		Effective Date:
Policy Holder's SSN:		
Policy Holder's DOB:		

I authorize the release of any medical information necessary to process this bill to my insurance company. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

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