Patient Registration

Name: _____
First Name MI Last Name Preferred Name

Birthdate: _____ Sex: ☐M ☐F E-mail address: _____

Address: _____ City: _____
_____ State: ___ Zip: _____

Home Phone: _____
Work Phone: _____
Preferred Phone Number: ☐Home ☐Work ☐Cell

Cell Phone: _____
Carrier: _____
Would you like to receive appointment reminders via text? ☐Y ☐N

Whom may we thank for referring you? _____

Insurance Information

Subscriber Information:
Name: _____ ID Number: _____ Birthdate: _____

Employer: _____ Group Name: _____ Group Number: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Your relationship to subscriber: _____

Secondary Insurance Information

Subscriber Information:
Name: _____ ID Number: _____ Birthdate: _____

Employer: _____ Group Name: _____ Group Number: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Your relationship to subscriber:

Signature on File

If you have insurance, please read and sign below so that we may submit claims on your behalf.

- I understand that I am responsible for all charges for dental service not paid by my insurance. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with insurance claims
- I authorize and direct dental payments from my insurance complany to be paid directly to Kerstin E Horbal, DDS

_____ Date:
Signature of Patient/Parent or Guardian