



REGISTRATION FOR MINORS OR STUDENTS

Date _____

Patient's Name _____ SEX M / F Date of Birth: _____ Age _____

(Last, First & Initial)

Patient's Address _____

Patient's Social Security # _____ Telephone # Home _____ Cell _____

Is patient a full time student? () Yes () No If yes, where _____ (Name of School) (State)

** PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION **

Father: _____ Date of Birth: _____ Last First M.I.

Address: _____ Phone: _____

Soc. Sec. #: _____ Employer: _____ Phone: _____

SURGICAL:

Insurance Company _____ Group # _____ Agreement / ID # _____

DENTAL:

Insurance Company _____ Group # _____ Agreement / ID # _____

Mother: _____ Date of Birth: _____ Last First M.I.

Address: _____ Phone: _____

Soc. Sec. #: _____ Employer: _____ Phone: _____

SURGICAL:

Insurance Company _____ Group # _____ Agreement / ID # _____

DENTAL:

Insurance Company _____ Group # _____ Agreement / ID # _____

Who may we thank for referring you to our office? _____

Family Dentist _____ Family Doctor/Physician _____

ACKNOWLEDGMENT AND AUTHORITY: I have completed this form fully and completely, and certify that I am the patient or the duly authorized agent of the patient furnishing the information requested. I also understand that if I am eligible for Medical Assistance, payment for this service will be made from Federal and State funds, and that any false claim, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I understand that, even if I have some type of insurance coverage, I AM RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED. I understand that if I have some type of insurance coverage, I authorize the release of any information related to my insurance claim and also authorize any group insurance benefits payable to me to be made to Reading Oral Surgery Group, Ltd. I also understand that I will be billed for any services covered by insurance if payment is not received within 45 days of the INITIAL claim. I also authorize the Reading Oral Surgery Group, Ltd. to perform a credit check through a bonded credit bureau or service if I elect a Payment Plan as a preferred method of payment. THERE WILL BE A \$30.00 CHARGE FOR ALL RETURNED CHECKS. THE POLICY IN THIS OFFICE IS the parent who requests treatment for the child is responsible for all fees for services rendered.

Signed _____ Signed (Parent) _____ (Patient - If Not Minor)

Witness



Date _____

PATIENT REGISTRATION

(IF UNDER 18 YEARS OF AGE OR COVERED UNDER PARENTS INSURANCE POLICY, PLEASE FILL OUT REVERSE SIDE OF FORM)

Patient's Name _____ (Last, First & Initial) SEX M / F Date of Birth: _____ Age _____

Patient's Address _____ Street _____ City _____ State _____ Zip _____

Patient's Social Security # _____ () Single () Married () Widowed () Divorced

Telephone # Home _____ Cell _____ Work _____

Patient's Employer Name _____

**** PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION ****

Do you have insurance through your employer? () Yes () No

SURGICAL: Insurance Company _____ Group # _____ Agreement / ID # _____	DENTAL: Insurance Company _____ Group # _____ Agreement / ID # _____
--	--

Do you have any other insurance coverage? () Yes () No (List Below)

This coverage is through: () SPOUSE () PARENT () OTHER _____

Their Name (Last, First & Initial) _____

Social Security #: _____ Date of Birth: _____

Place of Employment (Name & Address): _____

SURGICAL: Insurance Company _____ Group # _____ Agreement / ID # _____	DENTAL: Insurance Company _____ Group # _____ Agreement / ID # _____
--	--

Who may we thank for referring you to our office? _____

Family Dentist _____ Family Doctor/Physician _____

ACKNOWLEDGMENT AND AUTHORITY: I have completed this form fully and completely, and certify that I am the patient or the duly authorized agent of the patient furnishing the information requested. I also understand that if I am eligible for Medical Assistance, payment for this service will be made from Federal and State funds, and that any false claim, statements, documents, or concealment of material may be prosecuted under applicable Federal and State laws. I understand that, even if I have some type of insurance coverage, I AM RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED. I understand that if I have some type of insurance coverage, I authorize the release of any information related to my insurance claim and also authorize any group insurance benefits payable to me to be made to Reading Oral Surgery Group, Ltd. I also understand that I will be billed for any services covered by insurance if payment is not received within 45 days of the INITIAL claim. I also authorize the Reading Oral Surgery Group, Ltd. to perform a credit check through a bonded credit bureau or service if I elect a Payment Plan as a preferred method of payment. **THERE WILL BE A \$30.00 CHARGE FOR ALL RETURNED CHECKS.** THE POLICY IN THIS OFFICE IS the parent who requests treatment for the child is responsible for all fees for services rendered.

Witness _____

Signed (Patient/Parent) _____