Case Dental Medicine Support Services, LLC – New Patient Registration Form

❑ Dr. Hans	❑ Dr. Valiathan

Patient Information

Last Name	First Name	M.I.
Street Address	City/State	Zip

Home Phone	Cell Phone	Work Phone

Social Security Number	Date Of Birth	Patient's Sex ❑ Male ❑ Female

Email Address	Employer Name
Have you been to the Dental School before? ❑ Yes ❑ No	If yes, when?

Responsible Party Information

Responsible Party Name	Relationship To Patient

Street Address	City/State	Zip

Social Security Number	Date Of Birth

Emergency Contact

Name	Phone number	Relationship to patient

Primary Insurance Information

Primary Insurance Company

Insurance Address	City/State	Zip

Identification Number	Group Number

Subscriber Name	Relationship To Patient	Subscriber Birth Date

Employer Name (If Applicable)

Secondary Insurance Information

Secondary Insurance Company

Insurance Address	City/State	Zip

Identification Number	Group Number

Subscriber Name	Relationship To Patient	Subscriber Birth Date

Employer Name (If Applicable)

Payment Authorization Notice and Release of Information

In consideration of the services received or to be received, I hereby authorize payment directly to Case Dental Medicine Support Services, LLC, as may be payable to me for such services. I understand that I am financially responsible for charges not covered by this authorization, including deductibles and co-payments. Further, I hereby authorize Case Dental Medicine Support Services, LLC to release such information in connection with this treatment to my insurance company and/or hospital benefits program, wich is necessary for payment by same.

_______________________ Signature of patient or guardian

_______________________ Date signed