**Valerie D Hubbell, DDS**

# REGISTRATION FORM

(Please Print)

| | |
|---|---|
| Today's Date: | |

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's last name: First: Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐ | | |
| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: ☐ M ☐ F |
| Street address: | Social Security no.(For Insurance): | 1st Telephone #: 2nd Telephone #: | | | |
| P.O. box: | City: | State: | ZIP Code: | | |
| Occupation: | Employer: | Employer phone no.: ( ) | | | |
| Chose clinic because/referred to clinic by (Please check one box): | ☐ Dr. _____ | Fitness Center | ☐ Insurance plan | | |
| ☐ Family/Friend | ☐ Internet | ☐ Close to home/work | ☐ Phone Book | ☐ Other | |
| Other family members seen here: | | | | | |

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| | | | |
|---|---|---|---|
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: ( ) |
| Is this person a patient here? ☐ Yes ☐ No | | | |
| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
| Is this patient covered by insurance? ☐ Yes ☐ No | | | |

| | | | | | |
|---|---|---|---|---|---|
| Please indicate primary insurance | Name: | Phone #: | | | |
| Insurance Address: | | | State: | Zip: | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Deductible: $ |
| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other | |
| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: | | |
| Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other | |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*