Maple Brook Family Dentistry
Chad A. Borer, D.D.S

New Patient Registration

Patient Information

Patient Last Name	Patient First Name	MI	O Male O Female
Patient Birthdate __/__/__	Patient Social Security #		O Married O Single O Child O Other
Patient Address	City	State	Zip
O Home Phone	O Work Phone	O Cell Phone	O Email Address

Please check the phone number above that is your preferred daytime contact number.

Responsible Party *(If someone other than patient)*

Last Name	First Name	MI	O Male O Female
Birthdate __/__/__	Social Security #		O Married O Single O Child O Other
Address	City	State	Zip
O Home Phone	O Work Phone	O Cell Phone	O Email Address

Please check the phone number above that is your preferred daytime contact number.

Insurance Policy Holder Information *(Primary)*

Policy Holder Last Name	Policy Holder First Name	MI	O Male O Female
Policy Holder Birthdate __/__/__	Policy Holder Social Security # or Insurance ID #	Policy Holder relationship to Patient	
Policy Holder Address	City	State	Zip
O Home Phone	O Work Phone	O Cell Phone	O Email Address
Policy Holder Employer	Insurance Company Name	Group Number	

Secondary Insurance Information

Policy Holder Last Name	Policy Holder First Name	MI	O Male O Female
Policy Holder Birthdate __/__/__	Policy Holder Social Security # or Insurance ID #	Policy Holder relationship to Patient	
Policy Holder Address	City	State	Zip
O Home Phone	O Work Phone	O Cell Phone	O Email Address
Policy Holder Employer	Insurance Company Name	Group Number	

Release

I.) I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

II.) I hereby authorize payment of insurance benefits directly to Maple Brook Dental, otherwise payable to me.

III.) I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand that I am financially responsible for payments in full for all accounts I am responsible for as listed in the financial policy (NPFORM2). By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

IV.) I attest to the accuracy of the information on this page.

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Signature of Patient/ Responsible Party   *Date*