



Watermark Dental Patient Registration

please complete both pages of this form

Patient Information:

Referred By: _____

First Name:

Middle Initial:pa

Nickname/Preferred Name:

Last Name:

Street Address:

City, State, Zip:

Home Phone:

Work Phone:

Cell Phone:

Gender: Female Male

Marital Status: Married Single Divorced Separated Widowed

Birth date:

Social Security #:

E-mail:

I agree to receive email correspondences / text messages for appointment information

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Occupation:

Student Status: Full Time Part Time **Name and Address of School:**

Responsible Party is Policy Holder for Patient Primary Policy Holder Secondary Policy Holder

Responsible Party: (if someone other than the patient)

First Name:

Middle Initial:

Last Name:

Street Address:

City, State, Zip:

Home Phone:

Cell Phone:

Work Phone:

Birth date:

Social Security #:

Authorization and Release

I authorize the staff of Watermark Dental to release any information, including the diagnosis and records of treatment or examination to third party payors and/or health care practitioners. I authorize and request my insurance company to pay directly to Watermark Dental the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also agree to pay finance charges of 1.5% per month and/or a billing charge of \$2.00 on balances not paid in full within 60 (sixty) days of treatment. If collections or legal action occurs, I agree to pay those charges in addition to the account balance due. I certify that I have read and understand the above information.

Signature of Patient (or Guardian):

Date:

Primary Insurance Policyholder Information (if applicable):

Patient Relationship to Policyholder: Self Spouse Child Other

Name of Policyholder/Subscriber:

Address of Subscriber:

Social Security #:

Insured Birth Date:

Subscriber ID #:

Employer Group #:

Name of Employer:

Address of Employer:

City, State, Zip:

Phone #:

Insurance Company:

Claims Mailing Address:

City, State, Zip:

Phone #:

Secondary Insurance Policyholder Information (if applicable):

Patient Relationship to Policyholder: Self Spouse Child Other

Name of Policyholder/Subscriber:

Address of Subscriber:

Social Security #:

Insured Birth Date:

Subscriber ID #:

Employer Group #

Name of Employer:

Address of Employer:

City, State, Zip:

Phone #:

Insurance Company:

Claims Mailing Address:

City, State, Zip:

Phone #: