Armitage Oral Surgery **Registration Form**

Today's Date:

Patient Information

Patient's Name:		Legal guardian, if patient is a minor:	
Street Address	City	State	Zip Code
Birth date: Sex: ☐ Male ☐ Female	**Social Security number:**		
Occupation:	**Employer/Address**:		**Employer Phone:**
Patient's Dentist Name		Phone	
Address:			

Contact Information

Home Phone: Cell Phone: Work Phone: Email:	Emergency Contact Name: Phone: Relationship:

I authorize Dr. Katabi or a member of his staff to discuss any Protected Health Information with:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Referred to Armitage Oral Surgery by:
☐ Dr. _____ ☐ Other _____

Reason for your visit today, be specific:

INSURANCE INFORMATION

Please give your insurance cards to the receptionist

Patient covered by insurance: ☐ Yes ☐ No

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Subscriber's Name:	Subscriber's Address	Subscriber phone: ( )
Subscriber's Birth date:	Name of Primary Insurance:	Subscriber's SSN:
Policy no./ID:	Group #:	Subscriber's Employer:

Form of Payment for today's Procedure: ☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

PLEASE READ CAREFULLY:

- I understand **all fees are the responsibility of the patient or responsible adult (if patient is a minor) regardless of insurance or other benefits.**
- If, after 60 days, my insurance has not paid**, I understand I am responsible for the bill** and will incur the monthly finance charge of 1.5% (18% annual) on any unpaid balance after 60 days, even if insurance has not paid their portion.
- I authorize the release of any medical or other information necessary to process this claim.
- I hereby authorize insurance payments directly to the doctor of benefit for his services provided to me.
- I give permission to contact any of the phone numbers provided by myself.
- I understand **no pictures or video** will be allowed by anyone other than office staff.

Signature: **Date:**