NICOLE M. PAXSON, DDS

Gentle Family Dentistry

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Welcome to the office of Dr. Paxson. So that we may provide you with the best possible care, please complete this patient registration form and the medical/dental history forms. All information is completely confidential.
Thank you so much for the privilege to serve you!

PATIENT INFORMATION

Name (Last) (First) (Middle) Preferred Name Date of Birth / / Sex M F

Martial Status S M W D Social Security Number E-Mail Address

Street City Zip Code

Phone Numbers: Home Work Cell

Place of Employment Job Title

Responsible Party Drivers License # or State ID

Address (if different than patient)

Phone #'s (If different than patient) Home Work Cell

PATIENT INFORMATION

Primary Insurance Information

Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth: _____ Employer: _____

Insurance Company Name: _____ Phone #: _____

Insurance Contract ID#: _____ Group #: _____

Relationship to Patient: _____

Secondary Insurance Information

Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Date of Birth _____ Employer: _____

Insurance Company Name _____ Phone #: _____

Insurance Contract ID# _____ Group #: _____

Relationship to Patient _____

In Case of Emergency Call _____

How Did You Hear of Our Office? _____

_____

Authorization: I authorized and request my insurance company to pay directly to Dr. Paxson.
I authorized Dr. Paxson to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of this signature on all insurance submissions.

Signature _____

Date _____