Heritage Family Dental
General, Cosmetic & Implant Dentistry
Dr. Larisa Sokolson
Dr. Robert Burstein

PATIENT REGISTRATION FORM

Today's Date: ____/____/________

Welcome! Thank you for selecting Heritage Family Dental as your dental team. We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask – we will be happy to help!

Name: ______________________________ Nickname: ______________________ Sex: M F
Last *First* *Middle*

Social Security Number: ______________ Driver's License Number: ______________ DOB: ______________

Address: ______________________________ City: ______________ State: ______ ZIP: ______
Residence address

Home Phone: (_______) ______________ Cell Phone: (_______) ______________ Business Phone: (_______) ______________
Please include area code. *Please include area code.* *Please include area code.*

Where do you prefer to receive calls? Circle as many as apply. Home Cell Business

Email Address: ____

In the event of an emergency, whom should we contact?

Name: ______________ Relationship: ______________ Phone Number: (_______) ______________
Please include area code.

How did you hear about us?

____

Responsible Party (minor children or elderly guardianship)

Name: ______________________________ Relationship to Patient: ______________

Social Security Number: ______________ Driver's License Number: ______________ DOB: ______________

Address: ______________________________ City: ______________ State: ______ ZIP: ______
Residence address

Home Phone: (_______) ______________ Cell Phone: (_______) ______________ Business Phone: (_______) ______________
Please include area code. *Please include area code.* *Please include area code.*

Email Address:

____

Insurance Information

Primary Insurance	**Additional Insurance**
Name of Insured: ______________	Name of Insured: ______________
Relationship: ______________	Relationship: ______________
Insured DOB: ______________	Insured DOB: ______________
SS#: ______________	SS#: ______________
Employer: ______________	Employer: ______________
Employer Address: ______________	Employer Address: ______________
______________	______________
Insurance Company: ______________	Insurance Company: ______________
Insurance Co. Address: ______________	Insurance Co. Address: ______________
______________	______________
Ins. Co. Phone Number: ______________	Ins. Co. Phone Number: ______________
Group: ______________	Group: ______________
Subscriber ID#: ______________	Subscriber ID#: ______________

Authorization and Release

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such care to third-party payers and/or other healthcare practitioners.

I authorize and request my dental benefit plan to pay directly to the doctor or doctor's group benefits otherwise payable to me.

I understand I am responsible for payment of all services for myself and or my dependent(s). I understand all payments are due when services are rendered unless prior arrangements have been made. I am aware that a 1.5% monthly interest fee will be automatically added to my account if my balance is 21 days or older. I will only receive emergency treatment if my account is not current.

I understand two (2) working days notification is required to change an appointment for myself and my dependent(s). Working days are based on Dr. Sokolson and Dr. Burstein's office hours. A broken appointment fee may be charged to my account for missed appointments or last-minute cancellations.

Patient's Name (please print): ____

Patient/Parent/Guardian Signature: ______________________________ Date: ______________