Interbay Dental Specialists
945 Elliott Avenue West, Suite 210, Seattle, WA 98119
(206) 245 - 1693

CHART NUMBER

Patient Registration

This is a proprietary document. All information contained herein will be held in strict confidence.

PATIENT INFORMATION

Name

First Middle Last

Parent / Legal Guardian

First Last

Address

Street Address City State ZIP

Driver license #

Date of birth

/ /

Social security number

- -

Gender

☐ MALE ☐ FEMALE

Primary phone

( ) -

Alternate phone

( ) -

Email

Contact preferences
Check all that apply

☐ Text
☐ Email
☐ Automated call

EMERGENCY CONTACT

Name

First Last

Relationship

Primary phone

( ) -

Address

Street Address City State ZIP

Alternate phone

( ) -

EMPLOYMENT

Patient's place of employment

Employer address

Street address

City State Zip

Patient's work phone

( ) -

May we call you at work?

☐ YES ☐ NO

Spouse/Partner/Parent's place of employment

Employer address

Street address

City State Zip

Spouse/Partner/Parent's work phone

( ) -

May we contact your spouse/partner/parent at work?

☐ YES ☐ NO

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INSURANCE

PRIMARY COVERAGE	SECONDARY COVERAGE
☐ SELF ☐ SPOUSE/PARTNER ☐ PARENT	☐ SELF ☐ SPOUSE/PARTNER ☐ PARENT
Subscriber name First Last	**Subscriber name** First Last
Social security number - -	**Date of birth** / /
Social security number - -	**Date of birth** / /
Insurance company	**Insurance company**
Policy/ID number	**Group Number**
Policy/ID number	**Group number**
Insurance carrier address Street address City State Zip	**Insurance carrier address** Street address City State Zip
Insurance carrier phone ( ) -	**Insurance carrier phone** ( ) -

HOW DID YOU HEAR ABOUT INTERBAY DENTAL SPECIALISTS?

- ☐ Friend or family member: _____
- ☐ A social feed (e.g. Facebook, Twitter, Google+, etc.)
- ☐ Searching on the internet
- ☐ Walked past office before
- ☐ Physician Referral
- ☐ Other: _____

RELEASE

Assignment of Benefits and Release of Information

By my signature, I hereby acknowledge my responsibility to pay for services rendered to me and I authorize the release of any information required for payment or review of a dental claim except as prohibited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible for the cost of any and all services rendered to me or to my dependent children regardless of insurance coverage.

Signed: _____ Date signed: _____

Signature of patient (or parent/legal guardian)