Dental Associates of Baraboo ◊ 880 14th Street ◊ Baraboo, WI 53913 ◊ 608-356-6611

Please use [TAB] key or MOUSE to navigate through the Form.

PATIENT REGISTRATION (ADULT)

Dental Associates of Baraboo requires a Social Security number in order to submit this form electronically.

PATIENT INFORMATION

Last Name: _____ **First:** _____ **MI:** ___ **Sex: Male** ◯ **Female** ◯

Date of Birth: _____ *(mm/dd/yy)* **Social Sec. #:** _____ *(xxx-xx-xxxx)*

Home Address: _____ **City/State:** _____ **Zip:** _____

Phone Home: _____ **Cell:** _____ **Email:** _____

Marital Status: Single ◯ **Married** ◯ **Divorced** ◯ **Widowed** ◯

Employer: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

SPOUSE INFORMATION (if applicable)

Last Name: _____ **First:** _____ **MI:** ___ **Sex: Male** ◯ **Female** ◯

Date of Birth: _____ *(mm/dd/yy)* **Social Sec. #:** _____ *(xxx-xx-xxxx)*

Home Address: _____ **City/State:** _____ **Zip:** _____

Phone Home: _____ **Cell:** _____ **Email:** _____

Employer: _____ **Occupation:** _____

Business Address: _____ **Business Phone:** _____

How would you prefer to be notified of appointments and other information?

Home Phone ☐

Cell Phone ☐

Work Phone ☐

Text Message ☐ **(If you choose Text Message, please select an additional method as well)**

Email ☐ _____ **(preferred email address)**

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DENTAL INSURANCE INFORMATION

Primary Dental Insurance: **Yes ◯ No ◯**

If Yes, Policy Holder Name: _____ Date of Birth: _____ *(mm/dd/yy)*

Holder's Social Security#: _____Type of Coverage: Individual ◯ Family ◯

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

Secondary Dental Insurance: **Yes ◯ No ◯**

If Yes, Policy Holder Name: _____ Date of Birth: _____ (mm/dd/yy)

Holder's Social Security#: _____Type of Coverage: Individual ◯ Family ◯

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

Tertiary(3rd) Dental Insurance: **Yes ◯ No ◯**

If Yes, Policy Holder Name: _____ Date of Birth: _____ (mm/dd/yy)

Holder's Social Security#: _____Type of Coverage: Individual ◯ Family ◯

Insurance Company Name: _____

Insurance Co. Address: _____

Group #: _____ Policy/Sub #: _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to *Dental Associates of Baraboo*, of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

_____ _____

Patient's Signature Date

Please note: Dental Associates of Baraboo will not share your information with outside sources.