PATIENT REGISTRATION

Today's Date: _____ **Chart #: _____**
Patient's Name: _____
Sex: ____ Male; ____ Female **Marital Status: ____ Single; ____ Married; ____ Other (_____)**
Patient's Date of Birth: _____ **Patient's SS#: _____ - _____ - _____**
Street Address: _____
City: _____ **State: _____** **Zip: _____**
Phone #s: Home: _____ **Cell: _____** **Work: _____** **Ext. _____**
E-mail Address (will not be shared with others):_____

Primary Physician's Name: _____ **Phone #: _____**
If applicable, Specialist Physician's Name: _____ **Phone #: _____**
Preferred Pharmacy: _____ **Phone #: _____**

If Patient is a minor, name of Parent/Guardian completing this form: _____

Person financially responsible for dental services provided on Patient (including <u>all</u> charges if you are not insured, <u>as well as</u> deductibles, co-pays, and any charges unpaid by insurance plans, if you are insured):
Name: _____ SS#:_____ - _____ - _____ Relationship to Patient: _____
Phone #s: Home: _____ Cell: _____ Work: _____
Responsible person's address, if different than Patient's:_____

In an emergency, please notify: _____ Phone: _____
Relationship to Patient: _____

How did you choose Dr. Sober? ____ Walked-in; ____ Saw sign; ____ Phone Book; ____ Internet; ____ Referred
If referred, by whom? _____

INSURANCE INFORMATION

Is Patient covered by one or more dental insurance plans? ____ Yes; ____ No If yes, how many? _____
<u>Primary Insurance</u>, if applicable:
Insurance Company: _____ Phone #: _____
Insured Subscriber's ID#:_____ Group #: _____
Insured Subscriber's Name (if other than Patient): _____
If not Patient, Subscriber's Date of Birth: _____ SS#: _____ - _____ - _____
Employer providing this dental plan: _____ Phone #: _____
<u>Secondary Insurance</u>, if applicable:
Insurance Company: _____ Phone #: _____
Insured Subscriber's ID#: _____ Group #: _____
Insured Subscriber's Name (if other than Patient): _____
If not Patient, Subscriber's Date of Birth: _____ SS#: _____ - _____ - _____
Employer providing this dental plan: _____ Phone #: _____

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STEVEN J. SOBER, D.M.D.
13330 W. Colonial Drive, Suite 120, Winter Garden, FL 34787

Authorization for use of "SIGNATURE ON FILE" on insurance claims

By my signature below, I hereby authorize the office of Steven J. Sober, D.M.D. to use the words <u>SIGNATURE ON FILE</u> in place of my actual signature for the purposes listed below:

1. **The release of my personal information to my insurance company as is required in order to process any claims on my behalf**
2. **To authorize insurance payments to be made directly to Steven J. Sober, D.M.D., for claims submitted by his office on my behalf or on behalf of any of my dependents named below, who are covered by my insurance.**

Signature: _____ Date: _____

Dependents: _____ _____

_____ _____

_____ _____