THOMAS J. HERRICK, D.D.S.

PATIENT REGISTRATION FORM

Patient Name _____ Middle initial:____. Social Security #: _____-_____-____
Date of Birth: _____/_____/_____ *circle one: Male Female / *circle one: Married/Single/Divorced/Widow
Address:_____ city: _____ state: _____ zip:_____
Home Phone: _____ cell #:_____ E-mail Address: _____
Do we have permission to send appointment reminders to your email? Yes No
Employer Name: _____Employer Phone Number: (_____) _____
Employer Address: _____
Primary Care Physician: _____phone#:_____
How did you hear about our Practice? _____
_____

Person responsible for bill such as a parent or guardian (Complete only if different from patient)
Guarantor Name: _____ Social Security Number: _____ - _____ - _____
Relationship to Patient: self ( ) spouse ( ) or parent ( ) Date of Birth: _____/_____/_____
Address: _____ Phone Number: _____
Employer Name: _____ Employer Phone Number: (___) _____
Employer Address: _____

Who to call for an emergency:
Name: _____ Address:_____
Home Phone: (__) _____ - _____ cell or work Phone: (___) _____-_____ Relationship: _____
_____

FIRST INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

THIRD INSURANCE INFORMATION
Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F
_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y _____ N_____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process my claims to my insurance company, and request payments go to Dr. Thomas J. Herrick. I acknowledge that I am financially responsible for payment whether or not it is covered by insurance.
Signature: _____ Date: _____