Dr. Nick Konopada and Associates Patient Registration

PLEASE COMPLETE THE FOLLOWING PERSONAL INFORMATION

Name:_____ Male___ Female____

Mailing Address:_____

City: _____ Province:___ Postal Code:_____ Home Ph:_____

Work Ph: _____ Cell Ph:_____ Email:_____

Date of Birth :_____ Spouse/Partner's Name_____

Is another member of your family a patient in our practice?_____

Emergency Contact:_____ Phone Number_____

IF THE PATIENT IS A MINOR CHILD, PLEASE PROVIDE INFORMATION OF PARENT OR GUARDIAN:

Parent or Guardian_____ Work Phone Number_____

Cell Number _____ Does the child reside with you at the above address? Yes____ No____

If not, please provide the contact person and place of residence:_____

_____ Alternate Phone Number: _____ Cell No: _____

DENTAL INSURANCE INFORMATION:

Insurance Company:_____ Employer:_____

Member's Name_____ Date of Birth_____

Group/Contract Number:_____ Identification Number:_____ Dep. No:_____

Percentages: Basic: ____% Major_____% Ortho:_____% Deductable: $_____ Annual Limit $_____

Secondary Plan, if applicable:

Insurance Company:_____ Employer:_____

Member's Name_____ Date of Birth_____

Group/Contract Number:_____ Identification Number:_____ Dep. No: _____

Percentages: Basic: ____% Major_____% Ortho:_____% Deductable: $_____ Annual Limit $_____

As a service to our patients, our practice directly bills most dental insurance companies. However, your specific policy is an agreement between you and your insurance company. You are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

Signature of Patient or Parent/Guardian: _____ Date:_____