Patient Registration Dr. Mark S. Zurawel, DDS

Patient Name ____ Preferred Name: _____________________

DOB: _____________Gender: ____ SSN: __________________ Email:________________________________

Phone: Home ___________________ Cell _______________________ Work______________________

Street Address: ____Apt #__________

City: ____State: ________Zip code: _________________

Occupation: ____________________________________ Employer: _________________________________

Circle one: Minor Single Married Widowed Divorced

Parent/Legal Guardian (if patient is a minor):____

EMERGENCY CONTACT Name: ________________________________ Phone: _______________________

Referred By: ____

FINANCIAL – I acknowledge that payment in full is due at the time of treatment, unless other arrangements are made prior to receiving dental treatment. Parents/Guardians are responsible for all fees and services rendered for treatment of a minor/child.

I authorize provider, insurer, or other organization to release any information regarding the dental history, treatment or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

I authorize payment to Dr. Mark Zurawel of the dental benefits otherwise payable to me.

I understand a 24 hour notice is required for rescheduling or cancelling appointments. Any cancelled, rescheduled, or missed appointment without 24-hour notice is subject to a charge. Repeated late cancellations or missed appointments will result in our office limiting you to same day appointments. If you have any questions regarding any of our policies, please ask a staff member and we will be happy to help. I certify the above information is true and accurate to the best of my knowledge.

X____ Date_______________________________

Signature of Patient or Parent (in case of Minor Patient)

INSURANCE INFORMATION - Providing your insurance information will allow us to better assist you should any further information be required to complete your self-claim with your insurance company.

Primary Insurance: ____

Subscriber ID:____ Group: ___________________

Policy Holder: ____ DOB: ____________________

Relationship to Policy Holder: ___________________________________

Filing Address: ____