Crescent Lake Dental - Glen J Marsack DDS

Patient Registration

Patient Name _____Email _____

Family Status: Married ____ Single____ Child_____ Other_____ Social Security _____-_____-_____

Birth Date: _____/_____/_____Email Address: _____

Phone: Cell _____Work _____Home _____

Address: _____ City _____Zip _____

Whom may we thank for referring you to our practice? _____

Primary Insurance

Insurance Name_____Phone Number_____

Subscriber Name_____Birthdate_____Relationship to Patient_____

Subscriber Social Security #_____Subscriber Employed by_____

Contract #_____Group #_____

Additional Insurance

Insurance Name_____Phone Number_____

Subscriber Name_____Birthdate_____Relationship to Patient_____

Subscriber Social Security #_____Subscriber Employed by_____

Contract #_____Group #_____

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Glen Marsack all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Marsack and his associates may use my health care information and may disclose such information to the above-named Company or any of my future medical/dental insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian Date

_____ _____

Please Print Name of Patient, Parent, Guardian Relationship to Patient