PATIENT REGISTRATION **Dr. Ronald F. Hull**

Patient's Name _____
Birth Date_____ Age_____Sex: Male/Female
Home Address _____
Phone Number(s): home(____)_____ work(____)_____cell(____)_____
Marital Status : Single Married Separated Widowed Divorced
Spouse's Name _____Work phone(____)_____
Student: Yes No School Name_____
Employer_____ SSN#_____
*Whom may we thank for referring you to Dr. Hull?*_____

Guarantor Information

(Person responsible for payment of account)

Guarantor's Name_____Relationship to Patient_____
Address_____
Home Phone (____)_____ Work Phone (____)_____
Employer_____ SSN#_____

Insurance Information

Employee's Name_____ SSN#_____
Employee's Date of Birth _____ Coverage: Family Individual
Employer_____Insurance Company_____
Policy #_____Group#_____ Ins. Co. Phone(____)_____

Emergency Contact

Name_____Relationship to Patient_____
Contact Phone Number(____)_____

Approved Method of Notice

(Appointment Reminders – voice - text – email - postcard)

Name _____ Phone number _____
Text message _____ email _____
Address _____

Assignment and Release

The information I have provided is accurate and complete to the best of my knowledge. **I acknowledge and agree that payment for services rendered is due at the time such service is performed and must be made in accordance with terms of the financial policy of Dr. Ronald F. Hull.** I consent to whatever procedures are necessary to diagnose my oral condition.

I authorize payments of benefits to Dr. Ronald F. Hull for services rendered under the terms of my insurance policy**. I understand that I am financially responsible for all charges *whether or not* paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Signature of Responsible Party Relationship Date