Dr. Mark Coussens, DMD

PATIENT REGISTRATION FORM

Patient's last name: First: Middle:			Birthdate:
Street address:			
P.O. Box:	City:	State:	ZIP code:
Cell phone # : ( ) -	Home phone # : ( ) -	Work phone # : ( ) -	
Marital status:	Spouse's name:	Email:	
List other family members with same contact information:			

☐ Do you want to receive an **email** for an appointment reminder?

☐ Do you want to receive a **text message** for an appointment reminder?

☐ Both

DENTAL INSURANCE INFORMATION

Primary insurance co.:		Phone number:
Mailing address:		
Subscriber name:		Relationship to subscriber:
Subscriber employer:		Subscriber Birthdate:
Subscriber SS # :	Group # :	ID # :

Secondary insurance co. (if applicable):		Phone number:
Mailing address:		
Subscriber name:		Relationship to subscriber:
Subscriber employer:		Subscriber Birthdate:
Subscriber SS # :	Group # :	ID # :

I authorize release of any information relating to dental work performed in this office and to release any information required to process my claims. I also authorize payment of all group insurance benefits to be made payable directly to Mark A. Coussens, DMD. I understand that I am responsible for all costs of dental treatment and agree to pay for them in full, at or before completion unless other arrangements are made with the office manager.

_____ _____

Patient/Guardian Signature Date