Bluejay Family Dentistry
Patient Registration

Welcome and thank you for selecting us for your dental care!
Please complete the information below. We are happy to assist or to answer any questions.

Patient Name_____ Birthdate _____/_____/_____

Name of legal guardian (if patient is a child) _____ Birthdate _____/_____/_____

Address _____
Street City State Zip

Home phone _____ Work phone _____ Cell phone _____

Email _____

Employer _____ Occupation_____

Emergency contact _____ Relationship _____ Phone _____

Do you have a dental benefit plan? ☐Yes ☐ No (If yes, please complete other side)

Whom may we thank for referring you to our office? ☐ Friend/Family/Co-worker_____

☐ Website ☐ Web search ☐ Mailer ☐ Other (please specify): _____

May we leave a detailed voice message on your home or cell phone? ☐ Yes ☐ No

Do you authorize us to speak to anyone about your dental care and/or dental account balance? ☐ Yes ☐No

If yes, please list the person(s) we may speak to: _____

Relationship to you: _____

Financially Responsible for Account (complete only if different from patient)

Name of person responsible for this account _____ Relationship to patient_____

Address _____
Street City State Zip

Home phone _____ Work phone_____ Cell phone _____ Birthdate ___/___/_____

Employer _____ Occupation_____

Employer Address _____
Street City State Zip

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I certify this information is true and correct to the best of my knowledge.

_____
Signature of patient (or legal guardian) Date

Dental Benefit Plan

Policy Holder's Name _____ Birthdate _____/_____/_____

Policy Holder's Address _____
Street City State Zip

Employer _____ Relationship to patient_____

Policy Holder ID # _____ Member ID # _____

Insurance company name _____ Group #_____

Insurance company phone number _____

Insurance company address _____
Street City State Zip

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____
Signature of patient (or legal guardian) Date

I hereby authorize payment directly to Dr. Alexis Simonson of the group insurance benefits otherwise payable to me.

_____
Signature of patient (or legal guardian) Date

Additional Dental Benefit Plan

Policy Holder's Name _____ Birthdate _____/_____/_____

Policy Holder's Address _____
Street City State Zip

Employer _____ Relationship to patient_____

Insurance company name _____ Group #_____

Policy Holder ID # _____ Member ID # _____

Insurance company phone number _____

Insurance company address _____
Street City State Zip

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____
Signature of patient (or legal guardian) Date

I hereby authorize payment directly to Dr. Alexis Simonson of the group insurance benefits otherwise payable to me

_____
Signature of patient (or legal guardian) Date