



PARTRIDGE PERIODONTICS

PERIODONTOLOGY, ORAL PLASTIC SURGERY, and IMPLANTOLOGY

5382 Cox-Smith Road
Mason, Ohio 45040
(513) 234 - 0465

7168 Beechmont Avenue
Cincinnati, Ohio 45230
(513) 231 - 2733

3655 State Route 73
Hillsboro, Ohio 45133
(937) 764 - 0333

PATIENT REGISTRATION

***IN ORDER TO SETUP AN ACCOUNT & PROCESS CLAIMS ACCURATELY, ALL PERTINENT INFORMATION MUST BE COMPLETED**

TODAY'S DATE: _____ EMAIL: _____

PATIENT NAME: _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

HOME #: _____ CELL #: _____

DOB: _____ AGE: _____ GENDER: MALE or FEMALE

SOCIAL SECURITY #: _____ REFERRED BY: _____

ARE OTHER MEMBERS OF YOUR HOUSEHOLD ESTABLISHED PATIENTS IN OUR OFFICE? YES or NO

IF YES, PLEASE GIVE THEIR NAMES: _____

CIRCLE ONE OR MORE OF THE FOLLOWING PAYMENT TYPES: DENTAL INSURANCE SELF PAY

INSURED'S NAME: _____ GROUP #: _____

INSURANCE CO (PRIMARY) _____ MEMBER #: _____

INSURANCE CO ADDRESS: _____

SECONDARY DENTAL INSURANCE

INSURED'S NAME: _____ GROUP #: _____

INSURANCE CO (SECONDARY) _____ MEMBER #: _____

INSURANCE CO ADDRESS: _____

IF PATIENT IS AN ADULT COMPLETE THIS SECTION

PLEASE CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

PATIENT'S OCCUPATION: _____ EMPLOYED BY: _____

WORK PHONE: _____ SSN# _____

IF RETIRED, FROM WHAT COMPANY: _____

SPOUSE NAME: _____ DOB: _____ SSN# _____

EMPLOYED BY: _____ WORK PHONE: _____

IF PATIENT IS A CHILD, COMPLETE THIS SECTION

FATHER: _____ DOB: _____ SSN# _____

MOTHER: _____ DOB: _____ SSN# _____

GUARDIAN: _____ DOB: _____ SSN# _____

ADDRESS (IF DIFFERENT FROM PATIENT'S)

FATHER'S: _____

EMPLOYED BY: _____ WORK #: _____

MOTHER'S: _____

EMPLOYED BY: _____ WORK #: _____

ACCOUNT RESPONSIBILITY

I AGREE THAT I AM RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR THIS PATIENT.

I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF DENTAL INSURANCE COVERAGE. PLEASE ALLOW AT LEAST ONE HOUR FOR YOUR FIRST APPOINTMENT.

PATIENT/PARENT/GUARDIAN'S SIGNATURE: _____

DATE SIGNED: _____

**FOR YOUR CONVENIENCE, OUR FINANCIAL POLICY IS ON THE REVERSE SIDE. UPON REVIEWING, PLEASE SIGN AND DATE. IF YOU SO DESIRE, YOU CAN RECEIVE A COPY AT YOUR APPOINTMENT.