NOVAK FAMILY DENTISTRY

Dr. Shauna Novak • Dr. Debra McGill

PATIENT REGISTRATION

First Name: ______________________ Last Name: ___________________________ Middle Initial: ____

Address: ____

City, State, Zip: ____

Home Phone: ____________________ Work: _____________________ Cell: ____________________

Birth date: ___________ Age: _____ Social Security: ______________ Drivers License: ______________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary insurance Policy Holder ☐ Secondary Insurance Policy Holder

Email: ____ ☐ I would like to receive correspondence via email

SECTION 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______________________________ Preferred Dentist: ___________________________

Employer ID: ______________________________ Preferred Pharmacy: _________________________

Carrier ID: ____

Additional Comments: ____

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PRIMARY INSURANCE INFORMATION

Name of Insured: ___________________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: _____________________ Insured Birth date: __________________________

Employer: ________________________________ Insurance Company ___________________________

Address: _________________________________ Address: _____________________________________

City, State, Zip: ___________________________ City, State, Zip: _____________________________

SECONDARY INSURANCE INFORMATION

Name of Insured: ___________________________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: _____________________ Insured Birth date: __________________________

Employer: ________________________________ Insurance Company ___________________________

Address: _________________________________ Address: _____________________________________

City, State, Zip: ___________________________ City, State, Zip: _____________________________

I, the undersigned, understand and agree that there will be an interest charge of 1.5% per month of any past due account over thirty days. I also understand and agree that if I am in default of this agreement, I will pay all the reasonable legal fees, court costs and other costs necessary to collect the debt, including fees charged by a collection agency.

Signature: ____ Date: ____________