Hughes Dental Group
Personalized & Comfortable

1580 S. WINCHESTER BLVD.
CAMPBELL, CA 95008
Tel: (408)378-3489

OFFICE USE ONLY

DATE
UPDATED _____

Patient Registration *(Please Print)*

Referred by _____ Date _____

PATIENT

Mr.
Mrs.
Miss

Patient | Last Name | First Name | Middle

Social Security # | Date of Birth | Sex | Marial Status | Home Phone

Address | Street | Apt. No. | City | State | Zip

Employed By

Employer's Address

Occupation | Bus. Phone

Spouse's Name | Employed By

Employer's Address

Occupation | Bus. Phone

Spouse's Social Security # | Date of Birth

INSURANCE

INSURANCE INFORMATION

(Be sure all information is listed)

Insurance -- Include Private, Group, and Spouse

	Insurance Company Name	**Policyholder (Subscriber)**	**Policy Number or Certificate Number**
1.			
2.			
3.			

Will this claim be covered under Worker's Compensation? Yes _____ No _____

If yes, Name of Company _____ Address of Co. _____

Ph. # _____ Treatment Authorized by _____

RESPONSIBLE PARTY

Mr.
Mrs.
Miss

Name | Address | City | State | Zip

Home Phone | Relationship to Patient | Occupation

Employer | Employer's Address | City | State | Zip | Bus. Phone

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services.

I understand that where appropriate, credit bureau reports may be obtained.

Date (today) _____ **Signature of Patient, or Parent, or Responsible Party** _____