

# COZY DENTAL

## Welcome Patient Registration

PATIENT NAME (Last, First, Middle Initial)		DATE OF BIRTH
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS
HOME PHONE	CELL PHONE	SEX male                      Female
PREFER ( ) Morning Appointments    Or    ( ) Afternoon Appointments		RELATIONSHIP TO INSURED Self    Spouse    Child
EMPLOYER		WORK PHONE
OCCUPATION		E-MAIL ADDRESS

### Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Referred to this office by:

NAME	PHONE
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### Insurance Information

#### Primary Coverage

#### Secondary Coverage

SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
DATE OF BIRTH	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE COMPANY
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
GROUP NUMBER	GROUP NUMBER
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION
SIGNATURE	DATE

### Verification of Benefits

For office use only Calendar Year	For office use only Calendar Year
Yearly Plan Maximum \$      Deductible \$	Yearly Plan Maximum \$      Deductible \$
Class 1      %    Class 2      %    Class 3      %	Class 1      %    Class 2      %    Class 3      %
Preauth/Films Necessary Yes    No Coverage for: FMX      BW	Preauth/Films Necessary Yes    No Coverage for: FMX      BW
PANO	PANO
ProDhv      Sealants	Prophy      Sealants
Electronic Pay Yes    No      Payor ID	Electronic Pay Yes    No      Payor ID
Mail Claim to	Mail Claim to