

**SOUTH PARK ORTHODONTICS**

**Paul A. DiFranco, DDS**

Patient Registration – Please **PRINT**

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Patient's \_\_\_\_\_ Patient's \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City – State – Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

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**Primary Insurance Information**

Primary Carrier \_\_\_\_\_ Phone # \_\_\_\_\_

Claims Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Guarantor Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Guarantor Birthdate \_\_\_\_\_

Relationship to Patient Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_ Employer Name \_\_\_\_\_

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**Secondary Insurance Information**

Secondary Carrier \_\_\_\_\_ Phone # \_\_\_\_\_

Claims Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Guarantor Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Guarantor Birthdate \_\_\_\_\_

Relationship to Patient Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_ Employer Name \_\_\_\_\_

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**PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD FOR A COPY**

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**Written Disclosure**

The doctor and/or staff of South Park Orthodontics have my permission to leave messages regarding my treatment, appointments and/or financial information on my answering machine.

\_\_\_\_\_  
Signature of Patient or Parent (If patient is under 18) \_\_\_\_\_ Date \_\_\_\_\_

**Release of Information**

I fully understand that I am solely responsible for my account balance regardless of delays or nonpayment by my insurance company. I hereby authorize **RELEASE OF ALL DENTAL/MEDICAL RECORDS NECESSARY** to my insurance company, in order that they may process and pay for any claims.

\_\_\_\_\_  
Signature of Patient or Parent (If patient is under 18) \_\_\_\_\_ Date \_\_\_\_\_

**Sign below if you wish benefits to be paid directly to the dentist**

I Authorize payment of dental benefits directly to the provider of services.

\_\_\_\_\_  
Signature of Patient or Parent (If patient is under 18) \_\_\_\_\_ Date \_\_\_\_\_