8408 davis blvd. #250
north richland hills, tx 76182

O - 817.812.2082
F - 817-812-2830

chad c. perry, dds

NEW PATIENT REGISTRATION

Please complete this form. If you have dental insurance we cannot file a claim for you unless the requested information is accurate. If you have dual dental insurance coverage, complete the information for the secondary carrier. Thank you.

Patient Name:_____ Date:_____

Patient SS#: _____ Date of Birth: _____ Sex: M or F

Address:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Work Phone:_____

Cell Phone:(_____)_____ Can we text your cell to confirm your appointment Yes_____ No _____

E-mail:_____ Can we email you to confirm your appointment Yes _____ No _____

Your preference for confirming your appointment would be calling: home ☐ work ☐ cell ☐ text cell ☐ email ☐

Patient's Employer:_____ Occupation:_____

Marital Status:_____ Spouse's Name:_____

Emergency Contact:_____ Phone#_____

How did you hear about us:_____

PERSON RESPONSIBLE FOR ACCOUNT: Same as above ☐

Name:_____ Relationship:_____ SS #_____

Address_____ City_____ State_____ Zip_____

Phone Home:_____ Work/Cell:_____

INSURANCE INFORMATION:

Primary Insurance Co:_____ Phone #_____

Address:_____ City/State _____ Zip_____

Group # _____ ID#_____

Employee:_____ Employer:_____

Date of Birth:_____ SS#_____ Relationship:_____

Secondary Insurance Co:_____ Phone #_____

Address:_____ City/State _____ Zip_____

Group # _____ ID#_____

Employee:_____ Employer:_____

Date of Birth:_____ SS#_____ Relationship:_____

COMMUNICATION RELEASE:

I authorize Chad Perry DDS and personnel to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history or any other related information to these listed below (physician, family member, etc)

Name_____ Phone_____Relationship_____

Name_____ Phone_____Relationship_____

*The duration of this authorization is indefinite unless otherwise revoked in writing.

I understand that payment is my obligation regardless of insurance or any other third party involvement

_____ _____ _____

Signature of patient/ Legally authorized representative Date Relationship

_____ _____ _____

Print Name Witness Date