FOREST HILLS

DENTAL CARE

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Responsible Party _____ (FIRST NAME) _____ (MIDDLE INITIAL) _____ (LAST NAME)

Patient _____ (FIRST NAME) _____ (MIDDLE INITIAL) _____ (LAST NAME)

Address _____ (STREET) _____ (APT #)

_____ (CITY) _____ (STATE) _____ (ZIP)

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ SSN _____ Email Address _____

Would you like to receive email reminders and special promotions? ☐ Y ☐ N

EMERGENCY CONTACT

Name _____ Relation _____

Daytime Phone _____ Cell Phone _____

EMPLOYER INFORMATION OF SUBSCRIBER INSURANCE

Employer's Name _____ Phone number _____

Address _____ (STREET) _____ (APT #)

_____ (CITY) _____ (STATE) _____ (ZIP)

Are you a full time student ☐ Y ☐ N If yes, where? _____

INSURANCE INFORMATION

If you do not know the following information please contact your insurance company by phone or internet

Subscriber's Name _____ SSN _____ Date of Birth _____

Insurance Company _____ Phone Number _____

Address _____ (STREET) _____ (APT #)

_____ (CITY) _____ (STATE) _____ (ZIP)

Plan Name _____ Group Number _____ Policy Number _____

Payor ID/Number _____ Individual Deductible $_____

Individual Yearly Max $_____ Renewal date _____

FOREST HILLS DENTAL CARE
foresthillsdentalco.com | P 303.840.9557 | F 303.766.3639
7450 S. Gartrell Road, Suite A9 | Aurora, CO 80016

SECONDARY INSURANCE INFORMATION

Subscriber's Name _____ SSN _____ Date of Birth _____

Insurance Company _____ Phone Number _____

Address _____
STREET APT #

_____
CITY STATE ZIP

Plan Name _____ Group Number _____ Policy Number _____

Payor ID/Number _____ Individual Deductible $_____

Individual Yearly Max $_____ Renewal date _____

REFERRAL SOURCE

How did you hear about us? _____

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Your portion of the bill will be due at time of service.

If your insurance has not paid within 60 days from the date from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution

_____ _____
SIGNATURE OF PATIENT (RESPONSIBLE PARTY OF MINOR) DATE

We are preferred providers with the following companies: Delta Dental, Blue Cross Blue Shield, Dentemax, Fortis, Guardian, Principal, United Concordia, Metlife, and Aetna.