## Allan J. Milewski, D.D.S. Inc. Patient Registration Form Name:\_\_\_\_ МΙ Last Birthdate:\_\_\_\_\_Social Sec #\_\_ Male Female Address:\_ City Street State Zip Home Phone \_\_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email: Preferred Contact method For General Contacts Cell Phone Home Phone Work Phone Email \_\_\_ Text Message Text Message For Recall Notices Cell Phone Home Phone Work Phone Email Text Message If you prefer text messages, who is your wireless carrier?\_ Emergency Contact:\_\_\_\_\_ Phone How did you hear about our office?: Dental Insurance Policy Subscriber Name: Date of Birth Subscriber's Relationship to Patient: \_\_\_\_\_\_Subscriber Social Sec #\_\_\_\_\_\_ Subscriber ID Insurance Company: Insurance Company Phone #\_\_\_\_\_ Fax #\_\_\_\_ Subscriber's Employer Group# Secondary Dental Insurance Policy \_\_\_\_\_ Date of Birth\_\_\_\_\_ Subscriber Name: Subscriber's Relationship to Patient: \_\_\_\_\_\_ Subscriber ID\_\_\_\_ \_\_\_\_\_Subscriber Social Sec #\_\_\_\_\_ Insurance Company:\_\_\_\_\_\_ Insurance Company Phone #\_\_\_\_\_ Fax # Group# Subscriber's Employer I authorize Dr. Allan J. Milewski to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such Dental Care to third party payers and or other health practitioners. I authorize and hereby request my insurance company to pay directly to Allan J. Milewski, D.D.S. Inc., Insurance Benefits otherwise payable to me. I understand that my dental benefits may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or the behalf of my dependents. signature Date: