

ROBERT M. BAGOFF, D.M.D., LLC

Patient Information

When registering, please present proof of insurance.

24 hour notice is required for cancellations. Service fee may be applied if less than 24 hour notice is given.

Payment is expected at the time of service.

PLEASE PRINT

DATE: _____ / _____ / _____ TITLE: (Ms., Mrs., Mr., Miss, Dr.) _____

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

BIRTH DATE: _____ / _____ / _____ SOCIAL SECURITY #: _____ / _____ / _____

HOME PHONE #: (_____) _____ - _____ WORK PHONE #: (_____) _____ - _____

CELL PHONE #: (_____) _____ - _____ PAGER #: (_____) _____ - _____

E-MAIL ADDRESS: _____

MAY WE CALL TO CONFIRM YOUR FUTURE APPOINTMENTS? YES NO

WHAT IS THE BEST WAY TO REACH YOU? _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

SPOUSE/GUARDIAN: _____

RELATIONSHIP: _____ PHONE #: (_____) _____ - _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

EMPLOYER: _____ PHONE #: (_____) _____ - _____

ROBERT M. BAGOFF, D.M.D., LLC

Patient Information

RESPONSIBLE PARTY (if other than patient or guardian) _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

EMPLOYER: _____ PHONE #:(____) _____ - _____

SOCIAL SECURITY #: ____ / ____ / ____

EMERGENCY CONTACT: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE #:(____) _____ - _____

PATIENT'S EMPLOYER: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE #:(____) _____ - _____

PAYMENT METHOD: CASH CHECK CREDIT CARD

MC/VISA/AMEX/DISCOVER #: _____

EXPIRATION DATE: _____

ROBERT M. BAGOFF, D.M.D., LLC

Patient Information

INSURANCE COMPANY: _____

INSURANCE CO. ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE #:(_____) _____ - _____ POLICY #: _____

GROUP #: _____ NAME OF INSURED: _____

INSURED'S ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

DATE OF BIRTH: ____/____/____ PHONE #:(_____) _____ - _____

INSURED'S SOCIAL SECURITY #: _____ - _____ - _____

OTHER INSURANCE: _____

INSURANCE CO. ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE #:(_____) _____ - _____ POLICY #: _____

GROUP #: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE: _____ DATE: _____