

Patient Registration

(Please fill in completely)

Name: _____ Sex: _____ Date: _____
What name would you prefer to be called? _____
Address: _____ City: _____
State: _____ Zip: _____ email address: _____
Ph #: _____ (cell/home/work) Ph #: _____ (cell/home/work)
Date of birth: _____ Employer: _____
Referred by: _____ Ph #: _____
Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Ph #: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of last visit: _____

Physician: _____ Ph #: _____
Address: _____ City: _____ State: _____ Zip: _____
Are you now under the care of of a physician? _____ If yes, for what reason? _____

Billing information

Medical insurance co.: _____ Subscriber's name: _____
Subscriber's DOB: _____ Relationship to patient: _____ **Please**
bring your insurance card to your appointment for the additional information needed to send a claim.

If related to an automobile accident or work related injury:

Auto insurance company/Workers comp insurance carrier: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of accident/date of injury: _____ Claim #: _____
Claim adjuster's name: _____ Ph#: _____

Record release: I hereby authorize Twin Cities TMJ & Facial Pain Clinic to release any information, including diagnosis and records of treatment, concerning my past medical history to my referring physician/dentist or other health care providers, insurance company and immediate family.

Patient signature: _____ Date: _____

(Parent or guardian, if patient is a minor)

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