Patient Registration

(Please fill in completely)

Name: ______________________________ Sex: M / F 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? Yes / No 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.**

<u>If related to an automobile accident or work related injury:</u>

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) Rev. 1/22/19