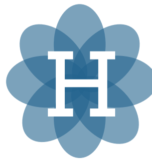

HAXTUN DENTAL CARE
115 S. Colorado Ave. Haxtun, CO 80731

Patient Registration Form

Patient Name ____
First Initial Last

Responsible Party (If someone other than the patient)

____
First Initial Last

Address ____
City ____________________ State ____________ Zip ____________
Home Phone ______________ Work ______________ Cell ______________
Birth Date ____________ Social Security ____________ Drivers License ____________
Email Address ____________________ ☐ Check if you would like to receive email reminders and promotions
Gender: Male ________ Female _______

Emergency Contact

Name ______________________________ Relationship To Patient ______________
Phone Number ________________

Employer Information of Subscriber Insurance

Employers Name ______________________ Phone Number ______________
Address ____
City ____________________ State ____________ Zip ____________
Full Time Student ☐ Yes ☐ No If yes, where ______________________

Insurance Information (if you do not know the following information please contact your insurance company by phone or Internet.)

Subscribers Name ______________ Social Security ____________ Birth Date ____________
Insurance Company ______________ Plan Name ______________
Phone Number ______________ Address ______________
City ______________ State ____________ Zip ____________
Group Number ______________ Policy Number ______________

Secondary Insurance Information

Subscribers Name ______________ Social Security ____________ Birth Date ____________
Insurance Company ______________ Plan Name ______________
Phone Number ______________ Address ______________
City ______________ State ____________ Zip ____________
Group Number ______________ Policy Number ______________

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 the time of service. If your insurance has not paid within 60 days 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, Parent or Guardian______________________ **Date**____________

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