Dr. Daniel M. Sarya, DDS, MPH

REGISTRATION FORM

(Please Print)

Today's date:	**Patient Number (office use only):**		
PATIENT INFORMATION			
Patient Last Name:	**First Name:**	**M.I.:**	**DOB:**
Mailing Address:	**Street Address:**		
City:	**State/Zip code:**		
Home Phone #: ( )	**Work Phone #: ( )**		
Cell Phone #: ( )	**Email address:**		
Dentist Name:	**Social Security #:**		
Current School Grade level:	**Patient School & phone #:**		
If patient is a minor, parent/guardian name:	**If patient is a minor, are they adopted or a foster child?**		
Whom may we thank for referring you:			
Other family members seen here:			
RESPONSIBLE PARTY & INSURANCE INFORMATION			
(Please give your DENTAL insurance card to the receptionist)			
1st Responsible Party Name:		**Marital status: S M D W Sep**	
Relationship to patient:			
Mailing Address:	**Street address:**	**Home #: ( )**	
City:	**State/Zip code:**	**Work #: ( )**	
Social Security #:	**Birthdate:**	**Cell #: ( )**	
Driver's License #:	**Email address:**		
Occupation:			
Employer name & address:		**Years employed:**	
DENTAL Insurance carrier/company:	**Group #:**	**Contract/Policy #:**	
2nd Responsible Party Name:		**Marital status: S M D W Sep**	
Relationship to patient:			
Mailing Address:	**Street address:**	**Home #: ( )**	
City:	**State/Zip code:**	**Work #: ( )**	
Social Security #:	**Birthdate:**	**Cell #: ( )**	
Driver's License #:	**Email address:**		
Occupation:			
Employer name & address:		**Years employed:**	
DENTAL Insurance carrier/company:	**Group #:**	**Contract/Policy #:**	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work/cell phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Dr. Daniel Sarya to perform orthodontic services and obtain any credit reports when necessary. I also authorize Dr. Daniel Sarya to release any information required to process my insurance claims.

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Patient/Guardian signature *Date*