DR. AUSTIN B. MEARES, D.M.D., P.A.

REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:				❑ Mr.❑ Mrs. ❑Dr. ❑ Miss❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #:	Drivers License #.: (- -)	Home phone #: (- -)
Street address:					Cell phone #: (- -)
P.O. Box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone #: (- -)
Email address:		Responsible party:			
Who referred you or how did you hear about our office, so we may thank them?					
Other family members seen here:		Pref. Pharmacy name and #:			

PRIMARY INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Policy holder (if other than the patient):	Birth date: / /	Address (if different):	Home phone #: (- -)
Policy holder's SS#:		Is the policy holder a patient here? ❑ Yes❑ No	
Policy holder's Occupation:	Employer:	Employer address:	Employer phone #: (- -)
Patients relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ other			
Name of primary insurance:		Insurance phone #:	
Street address	P.O. Box:	City:	State: ZIP Code:
Birth date: / /	Group #:	Policy #:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

SECONDARY INSURANCE INFORMATION

Policy holder (if other than the patient):	Birth date: / /	Address (if different):	Home phone #: (- -)
Policy holder's SS#:		Is the policy holder a patient here? ❑ Yes❑ No	
Policy holder's Occupation:	Employer:	Employer address:	Employer phone #: (- -)
Patients relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ other			
Name of secondary insurance:		Insurance phone #:	
Street address	P.O. Box:	City:	State: ZIP Code:
Birth date: / /	Group #:	Policy #:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY

Name :	Relationship to patient:	Home/cell phone #.:	Work phone #.:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Austin B. Meares, D.M.D., P.A. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*