MICHAEL F. REISCHL, D.D.S.
KENT PROFESSIONAL PLAZA
655 W. Smith • Suite 206 • Kent, WA 98032
(253) 854-8306

PATIENT REGISTRATION - CONFIDENTIAL

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SSN

PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS M☐ S☐ D☐ W☐	PATIENT'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

SPOUSE NAME LAST	FIRST	MIDDLE	SPOUSE EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME)

NAME WORK PHONE HOME PHONE

NAMES OF OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE YES☐ NO☐	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF☐ SPOUSE☐ DEPENDENT☐	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER — IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS

SECONDARY COVERAGE YES☐ NO☐	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF☐ SPOUSE☐ DEPENDENT☐	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER — IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

NAME	RELATIONSHIP TO PATIENT
ADDRESS	PHONE
ZIP	PHONE
EMPLOYER	OCCUPATION
ADDRESS	SOC. SEC. #

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and Xrays before, during and after treatment, if necessary, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____