Rhode Island Periodontics
Registration Form

Last Name:________________________________ First Name: ________________________

Address:____ Today's Date: ___________

City: ________________________________ State: _____________ Zip: _______________

Home Phone: __________________________ Cell Phone: ___________________________

DOB: ______________ Age: ___________ Sex: ___________ Marital Status: _________

General Dentist: ____

Authorization to leave phone message: Home: Cell:

Guarantor Information: (List person responsible for financial obligation)

Last Name: _______________________________ First Name :_______________________

Relationship to patient: Self _____ Spouse _____ Parent _____ Other __________

Address: ____

City: _____________________________ State: ______________ Zip: _____________

Home Phone: ________________________ Cell Phone: ___________________________

Date of Birth: _______________ Social Security #: _________________ Sex: _______

Employer Name and Address: ____

____ Work Phone: __________________

For patients with dental insurance:

Please note that we are considered out of network with all dental insurance companies. We will be happy to submit claims on your behalf so that you are reimbursed the maximum benefits that your plan allows. Please keep in mind that your dental insurance is a contract between you and the insurance company.

Insurance Information: Please attach copy of insurance ID cards

Primary Insurance:

Policy Holder Name: _____________________________ Date of Birth:_______________

Ins. Company Name: __________________________Group Name: ____________________

Subscriber ID #: ____________________________ Group #: ______________________

Claim mailing address: ____

Phone #: __________________ Relationship to Policy Holder: ___________________

Secondary Insurance:

Policy Holder Name: _____________________________ Date of Birth:_______________

Ins. Company Name: __________________________Group Name: ____________________

Subscriber ID #: ____________________________ Group #: ______________________

Claim mailing address: ____

Phone #: __________________ Relationship to Policy Holder: ___________________