



ARIZONA PERIODONTICS  
PATIENT REGISTRATION

Patient's Full Name \_\_\_\_\_  
First MI Last

Parent's Name \_\_\_\_\_

If Patient is a Minor First MI Last

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Social Security # \_\_\_\_\_

Name Of Spouse \_\_\_\_\_

First MI Last

Mailing Address \_\_\_\_\_

Street City State Zip

Home Phone: \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone : \_\_\_\_\_ Email \_\_\_\_\_

Best way to contact me : \_\_\_\_\_

Name of Patient's Employer \_\_\_\_\_

Address of Business \_\_\_\_\_

Street City State Zip

Present Position \_\_\_\_\_ How Long Held \_\_\_\_\_ Referred By \_\_\_\_\_

Your Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone Number (\_\_\_\_) \_\_\_\_\_

Insured's Full Name \_\_\_\_\_

First MI Last

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Relation \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Street City State Zip

Secondary Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone Number (\_\_\_\_) \_\_\_\_\_

Insured's Full Name \_\_\_\_\_

First MI Last

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Relation \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Street City State Zip

Patient Authorized Signature Form

As a courtesy to our patients we will file for dental insurance payment. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand I am financially responsible for all charges not covered by this assignment. Unpaid balances over 10 days of the monthly billing date will incur a monthly compounding interest rate of 5%. I realize that failure to keep this account current may result in my being unable to receive additional dental services except for dental emergencies or when there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

\_\_\_\_\_  
Signature Date

ANDREW E. DEEB, D.M.D., M.S., P.C.  
JANINA GOLOB DEEB, D.D.S., M.S.  
PERIODONTICS AND IMPLANTS  
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