CRANBERRY
FAMILY DENTISTRY
20215 Route 19 Suite 100 Cranberry Twp, PA 16066 724.742.1700 P 724.742.1722 F

REGISTRATION

(Please Print)

Email: _____

Date: _____ ***Home Phone:*** _____

PATIENT INFORMATION

Name: _____ Soc. Sec. # _____
last first MI

Address: _____

City: _____ State: _____ ZIP: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced

Employer: _____ Position: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency, please notify: _____ Phone: _____

PRIMARY INSURANCE

Name of Insured: _____
last first MI

Relation to Patient: _____ Birthdate: _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone: _____

City: _____ State: _____ ZIP: _____

Insured Employed by: _____ Business Phone: _____

Insurance Company: _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____ Relation to Patient: _____ Birthdate: _____

Address (if different from patient's) _____ Phone: _____

City: _____ State: _____ ZIP: _____

Insured Employed by: _____ Business Phone: _____

Insurance Company: _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan: _____

PRIMARY INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of insurance Company(ies)

and assign directly to Cranberry Family Denistry, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date