

Gateway Dental Centre  
 700 Fifth Avenue Suite 1616  
 Seattle, WA 98104-5000  
 (206) 343-8929  
 (Fax) (206) 343-9934

CHART NUMBER

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**PATIENT REGISTRATION**

**NOTE: THIS IS A PROPRIETARY DOCUMENT. ALL INFORMATION CONTAINED HEREIN WILL BE HELD IN STRICT CONFIDENCE.**

<b>P A T I E N T</b>	<b>NAME:</b> Last First Middle			Social Security Number		
	<b>ADDRESS:</b> Street City		State and Zip		BIRTH DATE   GENDER M   F	
	Home Phone ( )	Work or Cell Phone ( )	If Full Time Student - School		DRIVER LICENSE #	
	Whom Should We Contact In an Emergency? Name: Relationship: Address and Telephone #					
	Patient's Place of Employment			Spouse, Parent or Partner Place of Employment		
<b>E M P L O Y M E N T</b>	Address of Employer			Address of Employer		
	City State and Zip		City State and Zip		City State and Zip	
	Telephone Number Extension		Telephone Number Extension		Telephone Number Extension	
	May we call you during working hours?			May we contact this individual during working hours?		
	PRIMARY COVERAGE			SECONDARY COVERAGE		

<b>I N S U R A N C E</b>	Subscriber is: self   spouse   partner			Subscriber is: self   spouse   partner			
	Subscriber Name:			Subscriber Name:			
	Social Security Number		Birth date	Social Security Number		Birth date	
	Policy Number or Identification Number			Policy Number or Identification Number			
	Mailing Address of Insurance Carrier			Mailing Address of Insurance Carrier			
	City State and Zip		City State and Zip		City State and Zip		
	Effective Date		Contract Benefit Year		Effective Date		Contract Benefit Year
Mo: Date: Year:		Mo: Date: Year:		Mo: Date: Year:		Mo: Date: Year:	

How did you learn about Gateway Dental Centre?:

<b>R E L E A S E</b>	<b>ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION</b>	
	By my signature, I hereby acknowledge my responsibility to pay for services rendered to me and I authorize the release of any information required for payment or review of a dental claim except as prohibited by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible for the cost of any and all services rendered to me or to my dependent children regardless of insurance coverage.	

Signed: (Person Responsible for the Bill)

Date Signed