Registration

Repscher Dental

682 S. Ferguson Avenue, Suite #3
Bozeman, MT 59718
(406)-522-8801

Date________________ Home Phone ___________________
Cell Phone ________________

Patient Information

Name____ Soc. Sec. # ________________________
Last First Middle
Address____
City_________________________________ State______________ Zip Code ______________________
Sex □ M □ F Age__________ Birthday____________ □ Single □ Married □ Student □ Divorced
E-Mail Address_____________________________________
Patient Employer ____________________________________ Occupation_________________________
Business Address _______________________________________ Business Phone __________________
In case of emergency who should be notified? _________________________ Phone __________________
Who shall we thank for referring you?________________________________

Primary Insurance

Person Responsible for Account ____
Last First Middle
Relation to Patient __________________________ Birth date_____________ Soc Sec. #_______________
Address (if different from patient's) _______________________________Phone____________________
City ____________________________State__________________ Zip Code ____________________
Person Employed by ________________________________ Occupation___________________________
Business Address ____ Business Phone __________________
Insurance Company ____
Contract #_______________________Group #_____________________Subscriber #________________
Names of other dependents covered under this plan:
1. ________________________________ 2. __________________________________
3. ________________________________ 4. __________________________________
5. ________________________________ 6. __________________________________

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company
_____________________ and assign directly to Dr F. Jaeson Repscher 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