Patient Registration Form

Stamford Dental Group, LLC, 47 Oak Street, 2nd Fl, Stamford, CT 06905

Name:_____

Home Address:_____Apt.#_____

City:_____State:_____Zip:_____

Home Phone:_____ Work:_____

Cell:_____Fax:_____

Social Security Number:_____ Date of Birth:_____

Single Married Divorced Widowed

E-Mail Address:_____

How were you referred to our office? _____

Can we contact you through the internet? ☐ Yes, you may. ☐ No, you may not.

Primary Dental Insurance

Name of Guarantor:_____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Guarantor Name (If Different From Patient)_____

Social Security Number: _____

Date of Birth: _____

Please Note: As a courtesy, we will process your insurance claim(s). Please understand that we cannot process your insurance claim(s) until we have the proper insurance information. Please forward any questions and/or concerns directly to your insurance company. It is you, the patient, who has the relationship with your dental plan administrator and not our office. Notwithstanding insurance, the patient is responsible for payment at the time of service. For patients with insurance that we are in network with, we will accept partial insurance reimbursements(s) as payment. However, the patient remains responsible for any remaining balance not covered by their insurance company. I hereby authorize assignment of benefits to Stamford Dental Group, LLC.

Accepted Forms of Payment:
Cash, Check, Master Card, Visa, Discover Card, or Care Credit

_____ _____

Patient Signature/Parent if Minor Date