PRESTIGE®
ORAL & FACIAL SURGERY CENTER

5925 CROMO DR. STE. B, EL PASO, TX 79912 P: (915) 283-4730 | F: (915) 283-6210

REGISTRATION FORM

Date: _____

Patient Information					
Last Name:	First Name:	Middle Initial:	Date of Birth:		
Please Circle: Married Divorce Single		Patient Social Security #:	Phone Number:		
Mailing Address:		City:	St:	Zip:	
Email:	Employer:		How Logn Employed:		
Student:		Full Time:			
Billing Address:	City:	St:	Zip:		

Responsible Party			
Last Name:	First Name:	Date of Birth:	Driver License No:
Relationship to Patient:		SS:	

Primary Dental Insurance		Secondary Dental Insurance	
Subscriber's Name:	Sub DOB:	Subscriber's Name:	Sub DOB:
Sub ID/SS:		Sub ID/SS:	
Name of Insurance:		Name of Insurance:	
Insurance Address:		Insurance Address:	
Insurance Phone:		Insurance Phone:	
Group Name/Number:		Group Name/Number:	

Medical Insurance	
Subscriber's Name:	Sub DOB:
Sub ID/SS:	
Name of Insurance:	
Insurance Address:	
Insurance Phone:	
Group Name/Number:	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. i understand that i am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.	

Emergency Contact			
Name:	Relationship to patient:	Home phone no.:	Work phone no.: