Justin L Beasley D.D.S.
4600 W Memorial Rd
Oklahoma City, OK 73142

PATIENT REGISTRATION

Date_____ Home Phone (____)_____ Cell Phone (___)_____

Name _____ SS/HIC/ Patient ID# _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip _____

Sex O M O F Age _____ Birthdate_____ Married O Widowed O Single O

Divorced O Separated O Minor O

Patient's Employer/ School _____ Occupation_____

Employer/ School Address _____ Employer/ School Phone (___)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____ Phone (___)_____

PATIENT INFORMATION

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate _____ Soc. Sec. # _____

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

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address_____ Business Phone (___)_____

Insurance Company _____

Contract # _____ Group #_____ Subscriber # _____

Names of other dependents cover under this plan _____

SECONDARY INSURANCE

Is patient covered by additional insurance? O Yes O No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

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

City _____ State_____ Zip _____

Subscriber Employed by _____ Business Phone (___)_____

Insurance Company _____ Soc. Sec. # _____

Contract #_____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company

assign directly to Dr Justin Beasley 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 authorize the use of signature on all insurance submissions. The named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient