

Ryan W. Bucher, D.D.S.

PATIENT REGISTRATION

Patient Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ - _____ - _____ DOB: _____ - _____ - _____ Sex: M F Status: Single Other Married Child

Home Phone: _____ Cell: _____ E-Mail Address: _____

Referral Information: Family Internet Yellow Pages Newspaper School Work Other

Explanation: _____

Responsible Party: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

SS#: _____ - _____ - _____ DOB: _____ - _____ - _____ Sex: M F Status: Married Single Other Child

Primary Dental Ins. Co: _____ Ins. Phone# _____

Employer: _____ Insured: _____

SS#: _____ - _____ - _____ DOB: _____ - _____ - _____ ID#: _____ Group#: _____

Secondary Dental Ins. Co: _____ Ins. Phone# _____

Employer: _____ Insured: _____

SS#: _____ - _____ - _____ DOB: _____ - _____ - _____ ID#: _____ Group#: _____

Treatment Consent

I consent to treatment presented to me as diagnosed by Dr. Bucher. I understand that I am responsible for all charges. As a service to me, Bucher Family Dentistry will submit my dental claims for reimbursement. I accept responsibility for all charges not covered by the insurance plan and agree to make necessary arrangements in advance for my out of pocket expenses.

Signature _____ Date _____