DR. BRAD WELSH
& ASSOCIATES
GENERAL • BRACES • IMPLANT
DENTISTRY

Patient Registration
CONFIDENTIAL

330/674/4876
DrBradWelsh.com
fax 330/674/9175
231 Parkview Drive
Millersburg, Ohio 44654

Patient Information

Name _____ (_____) Date of Birth _____
First MI Last Nickname

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-Mail _____ Contact Preference: ❑ Voicemail ❑ Text ❑ E-Mail

Are you: ❑Male ❑Female

❑Minor _____
Parents' names

Employer (or School, if minor) _____ Occupation _____

Social Security Number _____ Whom may we thank for referring you? _____

Other Family members in the practice: _____

Person to contact in case of an emergency: _____
Name Phone Relationship

Responsible Party

Complete this section if responsible party is someone other than the patient.

Name _____ Date of Birth _____ Relationship to patient _____
First Last

Social Security Number _____ Employer _____
Name Phone

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-Mail _____ Contact Preference: ❑ Voicemail ❑ Text ❑ E-Mail

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 3.0% (36% APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made.

Responsible Party's Signature _____ Date _____

Dental Benefit Information

If you have no dental benefits disregard this section.

Primary Plan

Name of Policy Holder _____
Address _____
Phone _____
Birthdate _____ Relationship to patient _____
Social Security Number _____
Employer _____
Group Number _____ ID # _____

Secondary Plan

Name of Policy Holder _____
Address _____
Phone _____
Birthdate _____ Relationship to patient _____
Social Security Number _____
Employer _____
Group Number _____ ID # _____

I hereby authorize benefit payment directly to Dr. Brad Welsh's Office. I authorize this office to release any information my insurance company asks for, such as radiographs, dental history, and office/clinical notes. I understand that I am ultimately responsible for all costs of dental treatment.

Primary Policy Holder Signature: _____ Secondary Policy Holder Signature: _____

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