BenjaminT. Duval, D.D.S., L.L.C.
835 E. 65th Street, Suite 101
Savannah, GA 31405
912-352-4867

PATIENT REGISTRATION INFORMATION

Name_____
Address_____
City_____State_____Zip_____
Home Phone_____Cell Phone_____
Social Security #_____Birthdate_____Sex_____
Employer_____Occupation_____
Business Address_____Business Phone_____
Who referred you to our office?_____
In case of emergency, who should we contact_____Phone_____

PRIMARY INSURANCE

Person Responsible for Account_____
Relationship to Patient_____Birthdate_____SS#_____
Address_____Phone_____
City_____State_____Zip_____
Responsible Party Employed by_____Occupation_____
Business Address_____Business Phone_____
Insurance Company_____
Insurance Company Address_____
Subscriber/Policy#_____Group#_____

SECONDARY INSURANCE

Insured Name_____
Relationship to Patient_____Birthdate_____SS#_____
Address_____Phone_____
City_____State_____Zip_____
Insured Employed By_____Business Phone_____
Insurance Company_____
Subscriber/Policy#_____Group#_____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Benjamin T. Duval, DDS, LLC, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize Dr. Duval and/or any provider of services in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Additionally, if this dental office is forced to turn my account over to collections, I agree that I will be responsible for paying attorneys' fees and costs associated with the collections.

Signed_____Date_____