

*Welcome
to our family of patients*

New Patient Registration

				Today's Date	
Name,	First	MI	Last	Male/Female	Married/Single/Child
Street Address			Unit/Apt	Birthdate 00/00/0000	SSN
City		State	Zip	Primary Phone (H / W / C)	
E-Mail			Secondary Phone (H / W / C)		
Patient Employer			Phone	Person Financially Responsible for Patient/SSN	
Spouse Name / SSN		Spouse Birthdate 00/00/0000		Spouse Employer/Phone	

Insurance Information

Name of Insured/Employee	Primary Insurance	Group or Policy #
Secondary Insurance	Secondary Ins. Group or Policy #	Name of Insured / Secondary Ins.

May we thank someone for referring you to our practice?

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ & assign directly to the office of Dr. Erich Mock all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am fully responsible for all charges, whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Appointment cancellations must be made 48 hours in advance of scheduled appointments. Office visit charges will be billed for appointments failed without appropriate notification. Accounts over 60 days may accrue interest at 1% per month, 12% annually, and should my account be turned over to collections, the collection fee will be added to my account. I have read the above information and submit to the policies of the dental practice.

Responsible Party Signature

Mock Family Dentistry

Erich S. Mock, DDS, FAGD James Mock, DDS Ann Tran, DMD Stephen Stroh, DDS
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