Charles E. Hagan, D.D.S., M.H.S.
Juan C. Rodriguez, D.D.S., M.S.

Periodontics with Services in Dental Implants
Diplomates, American Board of Periodontology

335 West Lake Lansing Rd, Suite 100
East Lansing, MI 48823
(517) 336-9880
www.haganperio.com

PATIENT REGISTRATION PLEASE PRINT

PATIENT INFORMATION

First Name ______________ Last Name ______________ MI ______________ M / F

Social Security ______________ Birth Date ______________ Preferred Name ______________

Address ______________

City ______________ State ______________ Zip ______________

Home Phone ______________ Work Phone ______________ May we contact you at work? Y / N

Email ______________ Cell Phone ______________

If minor, parent / guardian name ______________

Employer ______________ Occupation ______________

Preferred Method of Contact *(please circle at least one):* Home Work Cell Email

Marital Status *(please circle):* Single Married Separated Divorced Widowed

In the event of an emergency, whom should we contact?

Name ______________ Relationship ______________ Phone # ______________

Name of Dentist or Person Who Referred You To Our Office ______________

INSURANCE INFORMATION

Primary Dental Insurance:

Insured's Name ______________ Relation ______________

Insured's Birth Date ______________ Insured's Social Security # ______________

Insured's Employer ______________ Insured's Occupation ______________

Insurance Company Name ______________ Insurance Company Phone # ______________

Insurance Group # ______________ Insurance Policy # ______________

Secondary Dental Insurance:

Insured's Name ______________ Relation ______________

Insured's Birth Date ______________ Insured's Social Security # ______________

Insured's Employer ______________ Insured's Occupation ______________

Insurance Company Name ______________ Insurance Company Phone # ______________

Insurance Group # ______________ Insurance Policy # ______________

AUTHORIZATION AND RELEASE

I authorize the dentist/staff to perform all necessary services that I may need during diagnosis and treatment with my informed consent. I authorize the dentist/staff to release any information including diagnosis and records of any treatment or examination rendered to third party payers and/or health practitioners. I authorize and request my dental company to pay directly to the dentist any insurance benefit otherwise payable to me. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for myself or dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient Signature ______________ Date ______________