Lekha Tull, DDS
214 N. Harrison Street
Princeton, NJ 08540
866-336-8855

PATIENT REGISTRATION SHEET

Today's Date: _____

PATIENT NAME: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____Work Phone #: _____

Employed by: _____ Email:_____

Social Security number: _____/_____/_____

Sex: M F Marital Status: Single Married Widowed Divorced

In case of emergency:

Name:_____ Phone:_____

Patient's Physician: _____ Phone:_____

Address_____

SPOUSES NAME: _____ Work Phone:_____

Social Security Number: _____/____/_____ Date of Birth: _____/_____/_____

Employed by: _____Address: _____

INSURANCE INFORMATION:

Primary: _____ Policy_____

Insured's Name: _____ Date of Birth:___/_____/_____

Insured's Employer:_____

Social Security #: _____/_____/ _____ Relationship to Insured_____

I hereby instruct and direct the above-mentioned insurance company to pay Lekha Tull DDS, for services rendered. I authorize the release of information to determine liability for payment and to obtain reimbursement. I understand that I am responsible for all charges incurred for services rendered.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE unless other arrangements have been made.

I authorize the release of any medical information necessary to process insurance claims and the release of payment of benefits to my dentist.

Patient's Signature: _____ Date: _____