Roger Baker, D.D.S.

Temporal Mandibular Dysfunctions

818 N. Emporia, Suite 101
Wichita, Ks. 67214

PATIENT REGISTRATION

Please Print Clearly Today's Date: 10/10/2013

Patient's Name: Testing Testing

Street Address: _____ Apt# _____

City: _____ State: _____ Zip _____

DateofBirth: _____ SS# _____ Sex: ___ MaritalStatus: ____

Home phone :( ) _____ Work Phone: ( ) _____

Cell phone :( ) _____ E-mail: _____

Employer'sName: _____ Dept: _____

Business Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Spouse/Parent/Guardian

Name: _____ SSN# _____

Date of Birth: _____ Sex: _____ Marital Status _____

StreetAddress: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone :( ) _____ Work Phone :( ) _____

Employer: _____ Dept: _____

Business Address: _____ Suite#: _____

City: _____ State: _____ Zip: _____

If Patient is a minor, please list other parent's information:

Name:_____ Address:_____

Phone :( )_____SSN#_____DateofBirth_____

Employer:_____

In Case of Emergency

Please list the closest living person, not living in your home.

Name:_____**Relationship:**_____

Address:_____**Phone:( )**_____

OFFICE POLICY

We **expect** payment for each office visit at the time of service. Due to the fact the TMJ treatment is exclusion under many insurance policies, we **do not** accept assignment of insurance benefits nor will we commence treatment contingent upon payment by an insurance carrier. After each visit you can request a super bill which will aid you in filing your insurance to be reimbursed for payments paid to our office. Please choose from the following methods of payments:

CASH☐ CHECK☐ VISA☐ MASTERCARD☐ DISCOVER☐

WELLS FARGO FINANCIAL☐ 6 MONTHS FREE INTEREST WAC

As a courtesy to all our patients we encourage you to call us as soon as you are aware that you cannot make a scheduled appointment. Please sign below so there will be no misunderstanding regarding our office policy.

CIRCLE WHICH FORM YOU WILL NEED TO FILE YOUR INSURANCE

☐ **MEDICAL FORM** ☐ **DENTAL FORM** ☐ **NONE**

_____

PATIENT OR GUARDIAN SIGNATURE DATE

ARE YOU A CURRENT MEDICARE RECIPIENT? **YES**☐ **NO**☐

PLEASE GIVE THE RECEPTIONIST YOUR CURRENT MEDICARE CARD TO MAKE A COPY TO KEEP IN YOUR FILE.