REGISTRATION
(PLEASE PRINT)

DR. WILLIAM E. HARTMAN & ASSOC.
13031 Kansas Avenue
Bonner Springs, KS 66012
Telephone: (913-441-1600

PATIENT INFORMATION

Date _____ Phone: Cell _____ Home _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ E-Mail: _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Payment is due at the time of service. For your convenience, we offer the following methods of payment. Please check the option which you prefer. ☐ Cash ☐ Check ☐ Credit Card

PRIMARY DENTAL INSURANCE

Subscriber Name _____ Birthdate _____ Soc. Sec. # _____

Subscriber Employed By _____ Business Phone _____

Business Address _____

Insurance Company _____ Insurance Telephone # _____

Insurance Address _____

Contract # _____ Group # _____

Names of other dependants covered under this plan _____

SECONDARY DENTAL INSURANCE

Subscriber Name _____ Birthdate _____ Soc. Sec. # _____

Subscriber Employed By _____ Business Phone _____

Business Address _____

Insurance Company _____ Insurance Telephone # _____

Insurance Address _____

Contract # _____ Group # _____

Names of other dependants covered under this plan _____

RESPONSIBLE PARTY

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

ASSIGNMENT AND RELEASE

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

_____ _____ _____
Responsible Party Signature Relationship Date