REGISTRATION

PATIENT'S NAME _____
Last First Initial

IF CHILD PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED?_____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE - STREET _____

CITY_____STATE_____ZIP_____

TELEPHONE: HOME_____OFFICE_____

CELL_____

EMAIL: _____

PATIENT/PARENT EMPLOYED BY_____

PRESENT POSITION_____HOW LONG HELD_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT_____

DRIVERS LICENSE NO._____

METHOD OF PAYMENT: Insurance ☐ Credit Card ☐ Cash ☐

PURPOSE OF CALL_____

OTHER FAMILY MEMBERS IN OUR PRACTICE

_____

WHOM MAY WE THANK FOR THIS REFERRAL

_____

PATIENT/PARENT SOCIAL SECURITY NO._____

SPOUSE/PARENT SOCIAL SECURITY NO._____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU:

_____PHONE:_____

Date _____ Date of Birth_____ Male ☐ Female ☐

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____#YRS_____

NAME OF INSURANCE CO._____

ADDRESS_____

_____

TELEPHONE_____

PROGRAM OR POLICY #_____

UNION LOCAL OR GROUP_____

SOCIAL SECURITY NO._____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____#YRS_____

NAME OF INSURANCE CO._____

ADDRESS_____

_____

TELEPHONE_____

PROGRAM OR POLICY #_____

UNION LOCAL OR GROUP_____

SOCIAL SECURITY NO._____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts. I understand that payment is due at the time of service unless previously agreed to otherwise and that I will be responsible for any costs of collection of past due accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____DATE_____