

PATIENT REGISTRATION

(PLEASE PRINT)

Date: _____

Patient _____ S.S.# _____
Last Name First Name Initial Nickname

Home Address _____ City _____ State _____ Zip Code _____

Home #() _____ Work #() _____ Cell or other _____ Best # to reach during business hrs. _____
(please circle one)

Sex: Male__ Female__ Date of Birth: _____ Drivers License # _____ Marital Status: Single – Married – Widowed
Separated - Divorced

Occupation _____ Employed By _____ How Long Held _____

Business Address _____ City _____ State _____ Zip Code _____

Spouse/Parent Name _____ S.S.# _____ Work #() _____ Date of Birth _____

Spouse Occupation _____ Employed by: _____ How long held? _____

Business Address _____ City _____ State _____ Zip Code _____

In case of an emergency, who should be notified? _____ Phone # _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Employee Date of Birth _____

Employer Name _____ Address _____ City _____ Zip Code _____

Insurance Co. Name _____ Address _____ City _____ Zip Code _____

Phone #() _____ Group or Policy # _____ S.S.# _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name _____ Employee Date of Birth _____

Employer Name _____ Address _____ City _____ Zip Code _____

Insurance Co. Name _____ Address _____ City _____ Zip Code _____

Phone #() _____ Group or Policy # _____ S.S.# _____

HEALTH INSURANCE COVERAGE

Employee Name _____ Employee Date of Birth _____

Employer Name _____ Address _____ City _____ Zip Code _____

Insurance Co. Name _____ Address _____ City _____ Zip Code _____

Phone #() _____ Group or Policy # _____ S.S.# _____

RELEASE:

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) health care for administering claims for insurance benefits.
- I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided to another dentist/specialist.
- I hereby authorize payment of insurance benefits directly to the dentist otherwise payable to me.
- I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
- I understand I am financially responsible for payments in full the day of service. 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 payer.

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

Patient's or Guardian's Signature _____ Date: _____