Patient Registration Information

CONFIDENTIAL

Date_____

Patient's Name_____
Last First middle

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birthdate_____ Social Security #_____

If Patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office_____

Responsible Party Information

Name_____
Last First Middle

Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State_____ Zip_____

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.)_____ City_____ State_____ Zip_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouses's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Insurance Information

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No. / Local No._____

Insurance Co. Address_____

Do you have dual coverage? (Circle one) **Yes** **No** If yes please complete the following:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No. / Local No._____

Insurance Co. Address_____

Insured's Employer_____

Authorization, Release and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health pracitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X_____ _____
Signature of patient or parent/guardian if minor Date