PATIENT
Name:_____
Last First Initial

Date _____ Date of Birth _____ ❑ Male ❑ Female

IF CHILD:
Parent's Name _____
Last First Initial

How do you wish to be addressed: _____
❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Residence Address _____

City _____ State____ Zip____

Business Address _____

Telephone: RES._____ BUS._____

Patient/Parent Employed By _____

Present Position_____ How Long Held____

Spouse/Parent Name _____

Spouse 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 this 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.

_____

DENTAL INSURANCE 1st COVERAGE

Employee Name_____

Employee Date of Birth_____

Employer _____ No. of Years____

Name of Insurance Co._____

Address _____

_____

Telephone _____

Program or Policy No._____

Union Local or Group _____

Social Security No. _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name_____

Employee Date of Birth_____

Employer _____ No. of Years____

Name of Insurance Co._____

Address _____

_____

Telephone _____

Program or Policy No._____

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 than the actual bill for services.

I understand I am financially responsible for payments in full of all 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_____

REGISTRATION