PATIENT NUMBER

Patient's Name _____
Last First Initial

Date_____ Date of Birth_____ ❑ Male ❑ Female

If Child, Parent's Name _____

How do you wish to be addressed_____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street_____

City_____ State_____ Zip_____

Business Address _____

Telephone: Res._____ Bus. _____

Fax_____ Cell Phone #_____

Email _____

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 ❑ Cash ❑ Credit Card ❑

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_____Date of Birth _____
Employer Name_____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or Policy #_____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE
2ND COVERAGE

Employee Name_____Date of Birth _____
Employer Name_____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or Policy #_____
Social Security No. _____
Union Local or Group _____

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