Patient Registration

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IN ORDER TO SERVE YOU PROPERLY, WE REQUEST THE FOLLOWING INFORMATION. ALL INFORMATION WILL BE STRICTLY CONFIDENTIAL

Patient Information:

NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP: _____

SOCIAL SECURITY #:_____ BIRTHDATE: _____

PRIMARY PHONE: _____WORK PHONE: _____

OTHER PHONE: _____ EMAIL ADDRESS:_____

OCCUPATION: _____EMPLOYER:_____

EMPLOYER'S ADDRESS:_____CITY_____STATE:____ ZP:_____

PLEASE CIRCLE: FEMALE MALE MARITAL STATUS: M S D W

SPOUSE OR PARENT NAME: _____

IF STUDENT, NAME OF SCHOOL/COLLEGE:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____

PHONE:_____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU:_____

PHONE:_____

Responsible Party:

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT:_____

RELATIONSHIP TO PATIENT _____ PHONE #: _____

ADDRESS OF RESPONSIBLE PARTY:_____

EMPLOYER OF RESPONSIBLE PARTY:_____

WORK PHONE : _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? Yes No

*PLEASE READ AND SIGN THE FINANCIAL POLICY AGREEMENT ATTACHED

Dental Insurance Information:

NAME OF INSURED: _____RELATIONSHIP TO PT: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____

NAME OF EMPLOYER: _____ WORK PHONE :_____

INSURANCE COMPANY:_____ GROUP #:_____

INSURANCE COMPANY ADDRESS: _____PHONE #: _____

HOW MUCH IS YOUR DEDUCTIBLE: MAXIMUM ANNUAL BENEFIT:_____

DO YOU HAVE SECONDARY DENTAL INSURANCE? YES NO

*PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR FIRST APPOINTMENT

I authorize the release of any information, including diagnosis and the records of any treatment or examination rendered to me, my child or ward, during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand and agree that I am responsible for payment of all services rendered on my behalf or my dependents. This authorization shall remain valid and effective for one year from the date of signing.

DATE: _____ Signature:_____(signed)

Relationship to Patient:_____

FAILED DENTAL APPOINTMENTS CAUSE A WASTE OF VALUABLE PROFESSIONAL TIME AND DEPRIVE OTHERS OF TREATMENT. IF YOU CANNOT KEEP AN APPOINTMENT, YOU MUST NOTIFY OUR OFFICE AT LEAST 24 HOURS IN ADVANCE TO AVOID CANCELLATION OF YOUR APPOINTMENT.