PATIENT REGISTRATION

Today's Date: _____/_____/_____

Patient 's Name: _____ Preferred Name _____
LAST FIRST MIDDLE INITIAL

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____ ext.: _____

Social Security No: _____ - _____ - _____ Sex M ☐ F ☐ Date of Birth _____/_____/_____

Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ E-Mail _____

Patient Employed By _____

Business Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you? _____

Method of Payment: Check ☐ Credit Card ☐ Cash ☐ Care Credit ☐

Emergency Contact _____ Relationship _____ Phone (____) _____ - _____

PRIMARY INSURANCE

Employee Name _____
LAST FIRST MIDDLE INITIAL

Social Security No: (for filing insurance) _____ - _____ - _____

Date of Birth _____/_____/_____

Employer _____

Insurance Company _____

Street Address _____

City _____ State _____ Zip _____

Insurance Company Phone (_____) _____ - _____

Group or Policy # _____

Subscriber ID# _____

SECONDARY INSURANCE

Employee Name _____
LAST FIRST MIDDLE INITIAL

Social Security No: _____ - _____ - _____

Date of Birth _____/_____/_____

Employer _____

Insurance Company _____

Street Address _____

City _____ State _____ Zip _____

Insurance Company Phone (_____) _____ - _____

Group or Policy # _____

Subscriber ID# _____

STATEMENT OF CONSENT FOR TREATMENT

I authorize the dentist to perform diagnostic procedures and treatment as 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 authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental 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 _____

9/22/16