

# WELCOME

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Last First Initial

## PATIENT INFORMATION

Patient Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_

Single  Married  Other

Residence Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security No: \_\_\_\_\_

Driver's Licence No: \_\_\_\_\_

Best Number to reach you at:

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Fax Phone: \_\_\_\_\_

I agree to information by e-mail at:

\_\_\_\_\_

## PATIENT EMPLOYMENT INFORMATION

Employed By: \_\_\_\_\_

Present Position: \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Social Security No: \_\_\_\_\_

Drivers License No: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best Number to reach you at:

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Other Family Members in this Practice: \_\_\_\_\_

\_\_\_\_\_

Whom may we thank for this referral: \_\_\_\_\_

\_\_\_\_\_

Someone to notify in case of emergency: \_\_\_\_\_

\_\_\_\_\_

## Dental Insurance- 1st Coverage

Name on Policy \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

Insurance Phone \_\_\_\_\_

Program or Policy # \_\_\_\_\_

Union Local or Group \_\_\_\_\_

## Dental Insurance- 2nd Coverage

Name on Policy \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

Insurance Phone \_\_\_\_\_

Program or Policy # \_\_\_\_\_

Union Local or Group \_\_\_\_\_

## Medical Insurance

Name on Policy \_\_\_\_\_

Employer Name \_\_\_\_\_

Insurance Company \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

Insurance Phone \_\_\_\_\_

Program or Policy # \_\_\_\_\_

## 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 payment of insurance benefits directly to the dentist 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 at the time of treatment. 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 understand fees are applicable for missed appointments.

I attest to the accuracy of the information on this page.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

# REGISTRATION