PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name _____ DOB _____ Male ___ Female ___
How do you wish to be addressed? _____ SS # _____
Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Full time student ___
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell _____ Work _____
Email _____ Who may we thank for referring you? _____
Employer _____ Occupation _____ How long there _____
Someone to notify in case of emergency _____ Phone _____
Other family members in this practice _____

ACCOUNT INFORMATION

Responsible Party's Name _____ DOB _____ Male ___ Female ___
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell _____ Work _____

PRIMARY DENTAL INSURANCE

Insured's Name _____ DOB _____
Employer _____ Occupation _____
Relationship to patient: Self __ Spouse __ Parent __
Name of Insurance Co. _____ Phone _____
Address _____ City _____ State ____ Zip _____
Policy/Group # _____ Insured's ID # _____

SECONDARY DENTAL INSURANCE

Insured's Name _____ DOB _____
Employer _____ Occupation _____
Relationship to patient: Self __ Spouse __ Parent __
Name of Insurance Co. _____ Phone _____
Address _____ City _____ State ____ Zip _____
Policy/Group # _____ Insured's ID # _____

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 otherwise payable to me.
I attest to the accuracy of the information on this form.

Patient's or Guardian's Signature _____ Date _____