REGISTRATION

PATIENT'S NAME ______________________________
Last First Initial

☐ Single ☐ Married ☐ Divorced ☐ Widowed

HOW DO YOU WISH TO BE ADDRESSED? ______________________

IF CHILD: PARENTS NAME ______________________________
Last First Initial

DOES CHILD LIVE WITH BOTH PARENTS?

☐ Yes ☐ No, Please explain ____________________

____

MAILING ADDRESS
STREET ______________________________

CITY ____________ STATE ____ ZIP ____________

HOME ADDRESS
STREET ______________________________

CITY ____________ STATE ____ ZIP ____________

Date __________ Date of Birth ______________

SOCIAL SECURITY NO. ______________________

HOME TELEPHONE ______________________

BUSINESS TELEPHONE ______________________

CELL TELEPHONE ______________________

E-MAIL ADDRESS ______________________

PATIENT/PARENT EMPLOYER ______________________

CURRENT POSITION ______________________

FOR HOW LONG ______________________

EMPLOYER ADDRESS ______________________

CITY ______________ STATE ____ ZIP ________

METHOD OF PAYMENT FOR PATIENT PORTION
☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

OTHER FAMILY MEMBERS IN THIS PRACTICE

____

WHOM MAY WE THANK FOR THIS REFERRAL

____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY

____

DENTAL INSURANCE COVERAGE – 1ST COVERAGE

EMPLOYEE NAME ______________________

EMPLOYEE DATE OF BIRTH ______________________

EMPLOYER ______________________

NAME OF INSURANCE CO. ______________________

ADDRESS ______________________

____

TELEPHONE ______________________

GROUP OR POLICY # ______________________

EMPLOYEE'S SOCIAL SECURITY # ______________________

DENTAL INSURANCE COVERAGE – 2ND COVERAGE

EMPLOYEE NAME ______________________

EMPLOYEE DATE OF BIRTH ______________________

EMPLOYER ______________________

NAME OF INSURANCE CO. ______________________

ADDRESS ______________________

____

TELEPHONE ______________________

GROUP OR POLICY # ______________________

EMPLOYEE'S SOCIAL SECURITY # ______________________

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 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 payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible to the accuracy of the information on this page.

Patient's or guardian's signature ______________________________ Date ______________