

PATIENT'S NAME: _____ **DOB:** _____
(Last) (First) (MI)

PATIENT'S PREFERRED NAME: _____ **SS #:** _____ **MALE** **FEMALE**

RESPONSIBLE PARTY: _____ **DOB:** _____
(Last) (First) (MI)

RELATIONSHIP TO RESPONSIBLE PARTY: _____

RESP. PARTY PREFERRED NAME: _____ **SS #:** _____ **MALE** **FEMALE**

RESP. PARTY MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER

HOME ADDRESS: _____ **MAILING ADDRESS:** _____

PHONE NUMBERS: _____ **EMERGENCY CONTACT:** _____

HOME: _____ **NAME:** _____

WORK: _____ **RELATIONSHIP:** _____

CELL: _____ **PHONE:** _____

EMPLOYER: _____ **POSITION:** _____ **HOW LONG?** _____

DRIVERS LICENSE #: _____ **STATE:** _____ **EMAIL:** _____

SPOUSE'S NAME: _____ **DAYTIME PHONE:** _____

METHOD OF PAYMENT: CASH CREDIT CARD CARECREDIT OTHER _____

DENTAL INSURANCE INFORMATION:

PRIMARY:

Employee's name: _____

Social Security #: _____ DOB: _____

Employee ID #: _____

Employer: _____

Insurance carrier: _____

Claims address: _____

Phone: _____ Group #: _____

SECONDARY:

Employee's name: _____

Social Security #: _____ DOB: _____

Employee ID #: _____

Employer: _____

Insurance Carrier: _____

Claims address: _____

Phone: _____ Group #: _____

****WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** _____

OTHER FAMILY MEMBERS IN OUR PRACTICE: _____

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 my 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 or dental group, otherwise payable to me.
I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
I understand that 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 payer.
I attest to the accuracy of the information on this page.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ **DATE** _____

REGISTRATION