

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

PREFERRED NAME: _____ SS #: _____ MALE FEMALE

RELATIONSHIP TO RESPONSIBLE PARTY: _____

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

PREFERRED NAME: _____ SS #: _____ MALE FEMALE

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED OTHER

HOME ADDRESS: _____ MAILING ADDRESS: _____

PHONE NUMBERS: _____ EMERGENCY CONTACT: _____
HOME: _____ NAME: _____
WORK: _____ RELATIONSHIP: _____
CELL: _____ PHONE: _____

EMPLOYER: _____ POSITION: _____ HOW LONG? _____

SPOUSE'S NAME: _____ DAYTIME PHONE: _____

METHOD OF PAYMENT: CASH CHECK CREDIT CARD CARECREDIT OTHER _____

DRIVERS LICENSE #: _____ STATE: _____

DENTAL INSURANCE INFORMATION

PRIMARY:	SECONDARY:
Employee's name: _____	Employee's name: _____
Social Security #: _____ DOB: _____	Social Security #: _____ DOB: _____
Employee ID #: _____	Employee ID #: _____
Employer: _____	Employer: _____
Insurance carrier: _____	Insurance Carrier: _____
Claims address: _____	Claims address: _____
Phone: _____ Group #: _____	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 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 payor 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 payor.
I attest to the accuracy of the information on this page.

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

REGISTRATION