Marina Bay Dental Associates P.C.
308 Victory Road
Quincy, MA 02171
Phone: 617-479-8080 Fax: 617-479-8189

Date _____

PATIENT INFORMATION

Date of Birth _____ ☐Male ☐Female ☐ Child*

Patients Name _____
Last First Initial

Nick-name/Prefers to be called _____

*(If patient is child)
Parents Name _____
Last First Initial

Patient/Parent Social Security Number _____

RESIDENCE

Street _____

_____
City State Zip

TELEPHONE (please check best way to contact you)

☐Home _____

☐Business _____

☐Cellular _____

☐Fax _____

☐Email _____

DENTAL INSURANCE COVERAGE

Insured Name _____

Insured Date of Birth _____

Insured Social Security Number _____

Insured Employer _____

Name of Insurance Company _____

Telephone _____

EMERGENCY CONTACT

Name _____

Phone _____

REFERRAL

Whom may we thank for this referral? _____

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 group, 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 service. 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