Date_____

PATIENT REGISTRATION

Phone No._____

PATIENT NAME_____ E-Mail _____
First Middle Last

Birthdate_____ Mr. Mrs. Miss Ms single married divorced widowed

Address_____
Street City State Zip

PATIENT

Employer_____

Bus. Address_____

_____

Bus. Phone or Cell _____

Bus. Address_____

SS#_____

YOUR SPOUSE

Name_____

Birthdate_____SSN#_____

Employer_____

Bus. Address_____

Bus. Phone or Cell_____

PERSON FINANCIALLY RESPONSIBLE

Name_____ Birthdate_____ SSN#_____

Address_____Phone No. _____
Street City State Zip

Employer_____Address_____

Bus. Phone No._____ _____

Relationship to patient_____

DENTAL INSURANCE COVERAGE Yes No

Employee Name_____Birthdate_____SSN#_____

Insurance Company_____Group No._____

Employer_____ Address _____

_____

SECONDARY INSURANCE COVERAGE Yes N

Employee Name_____Birthdate_____SSN#_____

Insurance Company_____Group No._____

Employer_____ Address _____

_____

Nearest Friend or Relative to Contact in case of Emergency? _____

Address_____Phone No._____

REFERRED TO US BY _____

AUTHORIZATION AND RELEASE: *I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Sign*_____.