Registration History

PATIENT INFORMATION

NAME _____ DATE _____
Last First MI

BIRTHDATE _____ AGE _____ SS# _____
Month Day Year

DRIVER'S LICENSE # _____ MALE FEMALE / SINGLE MARRIED MINOR
(Please circle responses)

ADDRESS _____
Street Apt # City State Zip

TELEPHONE _____
Home Work Mobile/Alternate

E-MAIL ADDRESS_____

PLACE OF EMPLOYMENT _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ YRS EMPLOYED _____

WHO MAY WE THANK FOR REFERRING YOU? _____

SPOUSE'S INFORMATION

SPOUSE'S NAME _____ DRIVER'S LICENSE # _____

BIRTHDATE _____ AGE _____ SS# _____
Month Day Year

EMERGENCY CONTACT INFORMATION

WHO SHOULD BE NOTIFIED IN CASE OF EMERGENCY? _____
Name Relationship to Patient Telephone Number

DENTAL INSURANCE INFORMATION

NAME OF INSURED/EMPLOYEE _____
Last First MI

INSURED SS# _____ BIRTHDATE _____

EMPLOYER NAME _____

DENTAL INSURANCE COMPANY _____

POLICY/GROUP # _____ TELEPHONE _____

CLAIMS ADDRESS _____

PLEASE LIST ALL COVERED FAMILY MEMBERS _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

AUTHORIZATION

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 for the purpose of treatment and administering claims for insurance benefits, including electronic submission of claims. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. Payment in full (or estimated co-payment and insurance assignment) is expected at the time of service. I attest that the information provided on this page is true and correct to the best of my knowledge.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____