



Patient's Name _____
Last First M.I. Birthdate Social Security #

About You

I like to be called _____

Home Address:
 Street _____

City _____ State _____ Zip _____

Billing Address (if different):
 Street _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed

Occupation _____

Employer _____

Whom may we thank for your referral? _____

Who is financially responsible for this account?

If this patient is a child, the parent or guardian who accompanies the child is responsible for payment of services.

About Your Insurance

PRIMARY

Employee Name _____

Employee Birthdate _____

Employer _____

Address _____

Insurance Co. _____

Address _____

Phone# () _____

Group# _____

SS# _____

ID# _____

SECONDARY

Employee Name _____

Employee Birthdate _____

Employer _____

Address _____

Insurance Co. _____

Address _____

Phone# () _____

Group# _____

SS# _____

ID# _____

Telephone Information

Home Phone () _____	Someone to notify in case of an emergency.
Work Phone () _____ ext. _____	
Pager/Car Phone () _____	
E-mail _____	
When is the best time to reach you? _____	
Where? _____ Specific Days? _____	
Name _____	Relationship _____
Home Phone () _____	Home Phone () _____
Work Phone () _____	Work Phone () _____

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 the release of any information concerning my (or my child's) health care and treatment from/to another dentist.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand 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