

welcome

REGISTRATION

Age _____ Date _____

Patient's Name _____ Date of Birth _____ Male Female
Last First Initial

How do you wish to be addressed _____

If Child: Parent's Name _____

Mailing Address _____

City _____ State _____ Zip _____

Residence Address _____

City _____ State _____ Zip _____

Single Married Separated Divorced Widowed Minor

Business Address _____

Telephone: Res. _____ Bus. _____

Cell Phone # _____

eMail _____

Send appointment reminders via: Text Message eMail

Patient/Parent Employed By _____

How Long Employed _____

Spouse/Parent Name _____

Spouse Employed By _____

How Long Employed _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance Cash Credit Card Care Credit

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

Phone: _____

DENTAL INSURANCE 1ST COVERAGE

Name of Policy Holder _____ Date of Birth _____

Address of Policy Holder _____

Relationship to patient _____

Employer Name _____

Name of Insurance _____

Address _____

Insurance Phone Number _____

Group Number _____

ID Number _____

DENTAL INSURANCE 2ND COVERAGE

Name of Policy Holder _____ Date of Birth _____

Address of Policy Holder _____

Relationship to patient _____

Employer Name _____

Name of Insurance _____

Address _____

Insurance Phone Number _____

Group Number _____

ID Number _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits 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 services, and that I am financially responsible for payment 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, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE _____