PATIENT REGISTRATION

Welcome!

Thank you for completing this confidential information to help us better serve your dental needs.

Date _____

PATIENT INFORMATION

Name _____
FIRST | MIDDLE | LAST | NICKNAME

Phone _____
HOME | WORK | CELL | EMAIL

Address _____
STREET | CITY | STATE | ZIP CODE

Other _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

RESPONSIBLE PARTY INFORMATION

Name _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Phone _____
HOME | WORK | CELL | EMAIL

Address _____
STREET | CITY | STATE | ZIP CODE

Other _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

DENTAL INSURANCE INFORMATION

Primary _____
INSURANCE COMPANY NAME | GROUP NUMBER

Insured _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Insured _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

Employer _____
EMPLOYER'S NAME | DATE EMPLOYED

Secondary _____
INSURANCE COMPANY NAME | GROUP NUMBER

Insured _____
FIRST | MIDDLE | LAST | RELATION TO PATIENT

Insured _____
DATE OF BIRTH | SOCIAL SECURITY | MARITAL STATUS | OCCUPATION

Employer _____
EMPLOYER'S NAME | DATE EMPLOYED

Who may we thank for referring you to our office? _____

In case of emergency, contact: _____
NAME | PHONE | RELATION TO PATIENT

CONSENT, ASSIGNMENT OF BENEFITS AND RESPONSIBILITY

I hereby authorize and request the performance of dental services for myself (or child). I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or the supervised staff. I hereby authorize this office to furnish information to insurance carriers concerning any treatment and I assign to the dentist all payments for dental services rendered to myself or my dependents. I understand that I am financially responsible for the services provided, regardless of insurance coverage and that payment is due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I promise to pay legal interest on the indebtedness together with collections costs and reasonable attorney fee.

_____
PATIENT OR GUARDIAN'S SIGNATURE | DATE