

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

RESIDENCE - STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

TELEPHONE: RES. \_\_\_\_\_ BUS. \_\_\_\_\_

CELLULAR \_\_\_\_\_ FAX \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PATIENT/PARENT EMPLOYED BY \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

WHO IS RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

DRIVERS LICENSE NO. \_\_\_\_\_

METHOD OF PAYMENT: Insurance  Credit Card  Cash

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 \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

### DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

### DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

### 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 release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, 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. 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