PATIENT REGISTRATION

LAST NAME:_____FIRST NAME:_____MIDDLE:_____

HOME ADDRESS:_____CITY:_____ST:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____SS#:_____

DOB:___/___/_____MARITAL STATUS: Single/Married/Partnered/Separated/Divorced/Widowed SEX: Male/Female

EMAIL:_____REFERRED BY:_____

EMPLOYER NAME AND ADDRESS:_____OCCUPATION:_____

EMERGENCY CONTACT:_____PHONE NUMBER:_____RELATIONSHIP:_____

DO YOU PREFER TEXT OR PHONE CALL REMINDERS?_____

PRIMARY INSURANCE

Subscriber Name/Address:_____

DOB:_____/_____/_____ SS#:_____

Relationship to Pt:_____

Employer Name:_____ Group #:_____

Insurance Co. Name/Address:_____

SECONDARY INSURANCE

Subscriber Name/Address:_____

DOB:_____/_____/_____ SS#:_____

Relationship to Pt:_____

Employer Name:_____ Group #:_____

Insurance Co. Name/Address:_____

AUTHORIZATION AND RELEASE

- I authorize the dentist to perform any and all diagnostic procedures such as radiographs, study models, photographs, and treatment (including local anesthetic) as may be necessary for proper dental care.
- I authorize release of any information concerning me or my child's health care, diagnosis, and treatment provided for purpose of evaluating and administering claims for 3rd party payers and/or other health care providers.
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand dentistry is not an exact science and guaranteeing results is impossible. I acknowledge that no guarantee has been made by anyone regarding dental treatment I have requested and authorized.
- I understand incorrect information may be hazardous to my health. I certify that I have read and understand the medical/dental questionnaire and have provided complete and accurate information. My questions have been answered to my satisfaction.
- In cases of divorce with dependent children, the accompanying guardian is responsible for payment on date of service.
- I understand that I am responsible for all costs of dental treatment.

PAYMENT DUE WHEN SERVICES RENDERED UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Signature of Patient and/or Guardian _____ Date_____