PATIENT INFORMATION

Name_____ Today's Date_____
LAST FIRST MI

Male Female (please circle) Age_____ Birthdate_____ Soc. Security #_____

Home Phone No._____ Minor Single Married Separated Widowed Divorced (please circle)

Cell Phone No._____ email address:_____

Home Address_____
CITY STATE Z

Spouse/Parent Name_____ Spouse/Parent Soc. Security #_____

Other family members in this practice_____

Whom may we thank for referring you?_____

Friend or Relative not living with you to notify in case of an emergency_____Phone_____

EMPLOYMENT INFORMATION

Patient/Parent Employed By:_____ Occupation_____

Business Address_____Business Phone_____Ext_____

Spouse/Parent Employed By:_____ Occupation_____

Business Address_____Business Phone_____Ext_____

BILLING INFORMATION

Person Responsible for Account_____
LAST FIRST MI

Relation to Patient_____Birthdate_____Phone_____ Soc. Sec. #_____

Address (if different from patient's)_____
CITY STATE ZIP

PRIMARY INSURANCE INFORMATION

Insurance Co. Name_____Insurance Co's Phone #_____

Insurance Co. Address _____
CITY STATE ZIP

Employer's Name_____ Subscriber's Name_____

Subscriber's Soc. Sec. #_____Group #_____Subscriber's Date of Birth_____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Co. Name_____Insurance Co's Phone #_____

Insurance Co. Address _____
CITY STATE ZIP

Employer's Name_____ Subscriber's Name_____

Subscriber's Soc. Sec. #_____Group #_____Subscriber's Date of Birth_____

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 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 realize 1.5% (18% APR) will be charged on balances over 30 days.
* I attest to the accuracy of the information on this page.
* I realize a collection fee will be charged for any uncollected balance that is transferred to a collection agency.

PATIENT'S OR GUARDIAN'S SIGNATURE_____DATE_____

REGISTRATION