Patient Registration

Patient Information:

First Name: _____ Last Name: _____ Middle Initial ____

Address (If insured, address that insurance company has on file):

_____ Apt #_____City/State/Zip:_____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ SS# _____ TDL#:_____

Date of Birth: _____ Age: _____ Marital Status: Married Single Separated

Employed By: _____ Occupation/Title: _____

Responsible party if minor: _____ Relationship to patient: _____

Address:_____ Telephone #: _____

Emergency Contact Name: _____ Relationship: _____

Phone #: _____ Address: _____

Do you have any family members who may need dental care? _____

How did you hear about our office? Referred By: _____ Internet Walked By

Other: _____ Voucher Number: _____

Dental Insurance Information:

Primary card holder's full name and relation to patient	I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for charges not covered by or paid by my insurance for whatever reason.
Insured's employer (if insurance through employer)	By signing below, I authorize that you may verify and exchange information on me and any additional applicants.
Insurance company name and address	I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance.
Insurance phone number	I authorize release of any information relating to any dental claim or claims. I understand that this dental practice is owned and operated and independent dentist.
Primary card holder's date of birth	I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental work.
Primary card holder's SS# /ID#	

Sign: _____ Date: _____