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REGISTRATION

PATIENT'S NAME _____
Last First Initial

Single Married Divorced Widowed
HOW DO YOU WISH TO BE ADDRESSED? _____

IF CHILD: PARENTS NAME _____
Last First Initial

DOES CHILD LIVE WITH BOTH PARENTS?
 Yes No, Please explain _____

MAILING ADDRESS STREET _____
CITY _____ STATE _____ ZIP _____

HOME ADDRESS STREET _____
CITY _____ STATE _____ ZIP _____

DENTAL INSURANCE COVERAGE – 1ST COVERAGE

EMPLOYEE NAME _____
EMPLOYEE DATE OF BIRTH _____
EMPLOYER _____
NAME OF INSURANCE CO. _____
ADDRESS _____
TELEPHONE _____
GROUP OR POLICY # _____
EMPLOYEE'S SOCIAL SECURITY # _____

Date _____ Date of Birth _____

SOCIAL SECURITY NO. _____

HOME TELEPHONE _____

BUSINESS TELEPHONE _____

CELL TELEPHONE _____

E-MAIL ADDRESS _____

PATIENT/PARENT EMPLOYER _____

CURRENT POSITION _____

FOR HOW LONG _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

METHOD OF PAYMENT FOR PATIENT PORTION
 Cash Check Credit Card Care Credit

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY _____

DENTAL INSURANCE COVERAGE – 2ND COVERAGE

EMPLOYEE NAME _____
EMPLOYEE DATE OF BIRTH _____
EMPLOYER _____
NAME OF INSURANCE CO. _____
ADDRESS _____
TELEPHONE _____
GROUP OR POLICY # _____
EMPLOYEE'S SOCIAL SECURITY # _____

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, 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 payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible to the accuracy of the information on this page.

Patient's or guardian's signature _____ Date _____