

Welcome

Age _____ Date _____

Patient's Name _____
Last First Initial

Date of Birth _____ Male Female

Dental Insurance 1st Coverage

If Child, Parent's Name _____

How do you wish to be addressed _____

Single Married Widowed Minor

Residence Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone Res. _____ Bus: _____

Fax _____ Cell phone _____

Email _____

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 _____

Driver's License No _____

Method of Payment Insurance Cash Credit Card

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 _____

Employee Name _____ Date of Birth _____

Employer's Name _____ Yrs _____

Name of Insurance Co. _____

Dental Insurance 2nd Coverage

Employee Name _____ Date of Birth _____

Employer's Name _____ Yrs. _____

Name of Insurance Co. _____

Consent :

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care options that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care: _____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill of services, and that I am financially responsible for payment in full of all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest the accuracy of the information on this page.

Patient's or Guardian's Signature _____

Date _____

REGISTRATION