PATIENT'S NAME _____
Last First Initial

IF CHILD, PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE-STREET _____

CITY _____ STATE ____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE RES _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD ____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____ BUS. PHONE _____

PRESENT POSITION _____ HOW LONG HELD ____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

METHOD OF PAYMENT: Insurance ☐ Credit Card ☐ Cash ☐

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 _____

_____

PATIENT'S BIRTH DATE _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE: _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

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, advise and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment.

I understand that I am responsible for all court costs and reasonable attorney fees.

I hereby authorize payment of Insurance benefits directly to the dentist or dental group, otherwise payable to me.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ **DATE** _____

REGISTRATION