PATIENT REGISTRATION

☐☐-☐☐☐☐

Patient Information

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐

If the patient is a minor please also complete the shaded Parent Information section immediately prior to Employment Information section.

Name ☐ Dr ☐ Mrs ☐ Ms ☐ Mr ☐ Miss _____ ☐ M ☐ F

Last *First* *MI* *Suffix (Jr., Sr., III, if any)*

Address Street _____ e-mail address: _____

City _____ State _____ ZIP Code _____

Telephone Numbers Home ( ) - Beeper ( ) -

Work ( ) - Other: (Specify) ( ) -

Social Security Number ☐☐☐-☐☐-☐☐☐☐ Age ☐☐ Birthdate ___/___/___

Month Day Year

Drivers License Number State _____ No _____

If patient is a minor (< 18 year old)

Parent Name _____ Parent Age ☐☐ Parent Birthdate ___/___/___

Month Day Year

Employment Information

Information below refers to the party that is responsible for the payment for dental services rendered.

Current Employer _____ Position or Title _____

Address City _____ State _____ How long Years _____ Months _____

Method of Payment

Cash ☐ Check ☐ Credit Card CC check ☐ Interest free financing ☐

Payment is expected when services are rendered unless other specific arrangements have been made with our business manager, prior to initiating care. We are happy to file your insurance claim for your refund.

Dental Insurance Information

The information below will assist us in filing your insurance claim for your refund.

Primary

Employees DOB: ___/___/___ *Month Day Year*

Company Name _____

SSN of Insured _____

Name of Insurance Carrier _____

Policy / Group Number _____

Telephone Number ( ) -

Secondary

Employees DOB: ___/___/___ *Month Day Year*

Company Name _____

SSN of Insured _____

Name of Insurance Carrier _____

Policy / Group Number _____

Telephone Number ( ) -

In case of an emergency

Please provide the name of an individual that we can contact in the case of an emergency.

Name _____ Relationship _____

Telephone Numbers Home ( ) - Beeper ( ) -

Office ( ) -

I certify that the above information is complete and accurate, to the best of my knowledge. I authorize the release of any information contained above for the purpose of obtaining my insurance reimbursement for my dental treatment. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services rendered. I understand that I am financially responsible for payments in full for all my accounts. By signing this statement, I agree to be responsible for payment for all services at the time they are rendered. The signature below may also be used as my ***Signature on File*** for filing my insurance claims for me.

_____ Patient Signature / Date

_____ Witness's Signature / Date

Patient Name :