PATIENT REGISTRATION

Patient Name: _____ **DOB:** _____

Home Address: _____ **Mailing Address:** _____

_____ _____

_____ _____

Male or Female **Social Security Number:** _____ **Marital Status:** S M D W

Phone Numbers:
Home: _____

Cell: _____

Work : _____

Emergency Contact:
Name: _____

Relationship: _____

Phone: _____

Place of Employment : _____ May we contact you at work? Y or N

Email Address: _____

DENTAL INSURANCE INFORMATION:

PRIMARY:

Employee's Name: _____

SS #: _____ DOB: _____

Employee ID #: _____

Employer: _____

Insurance Carrier: _____

Claims Address: _____

Phone _____ Group# _____

SECONDARY:

Employee's Name: _____

SS #: _____ DOB: _____

Employee ID#: _____

Employer: _____

Insurance Carrier: _____

Claims Address: _____

Phone _____ Group# _____

****WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** _____

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 my 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 or dental group, otherwise payable by me.
I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual billable services.
I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
I attest to the accuracy of the information on this page.

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