PATIENT REGISTRATION

Welcome! To provide you the best and most thorough care, please complete the following information and sign below. Thank-you!

PATIENT INFORMATION

PATIENT'S NAME: Last_____ First_____ Middle__ NICKNAME:_____ SEX: ☐Male ☐Female
ADDRESS Street_____ City_____ State_____ Zip _____ PHONE_____
MARITAL STATUS: ☐Married ☐Single ☐Divorced BIRTHDATE (MM/DD/YY)___/___/___ SOC. SEC.#____-___-_____
If Patient is a Minor, give Parent's or Guardian's Name_____ Today's Date_____
Who May We Thank for Referring You to our Office?_____
Reason for this Visit_____

RESPONSIBLE PARTY INFORMATION

NAME: Last_____ First_____ Middle____ MARITAL STATUS: ☐Married ☐Single ☐Divorced
MAILING ADDRESS: Street_____ City_____ State_____ Zip_____
HOME PHONE_____ WORK PHONE_____ SOCIAL SECURITY #___-___-_____
BIRTHDATE (MM/DD/YY)___/___/___ DRIVER'S LICENSE #_____ RELATION TO PATIENT_____
EMPLOYER_____ EMPLOYERS ADDRESS_____
OCCUPATION_____

RESPONSIBLE PARTY'S SPOUSE

NAME _____
EMPLOYER_____
Employer's address_____
OCCUPATION_____ WORK PHONE_____
SOC. SEC. #____-___-_____
BIRTHDATE (MM/DD/YY)___/___/___

EMERGENCY CONTACT:

NAME _____
ADDRESS_____
CITY, STATE_____ PHONE_____

RELATIVE NOT LIVING WITH YOU:

NAME _____
ADDRESS_____
CITY, STATE_____ PHONE_____

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURED'S NAME_____
DATE OF BIRTH(MM/DD/YY)___/___/___
INSURANCE CO. _____
INSURANCE CO. ADRESS_____
INSURANCE PHONE # (___) - _____
INSURED'S EMPLOYER_____
SOC. SEC. #____-___-_____ GROUP #_____

If you have double dental insurance coverage, complete this for the second coverage.

INSURED'S NAME _____
DATE OF BIRTH (MM/DD/YY)___/___/___
INSURANCE CO._____
INSURANCE CO. ADDRESS_____
INSURANCE CO. PHONE # (___) - _____
INSURED'S EMPLOYER_____
SOC. SEC. #___-___-_____ GROUP#_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. Failure to make a confirmed appointment may result in a charge to your account.

I have read the financial policy of this office and have completed the above form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

PATIENT Signature (Parent of Child)_____ Date:_____
FINANCIAL POLICY REVIEWED BY: (Staff)_____ Date:_____