

PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F
I prefer to be called: _____ Birthday: ____ / ____ / ____ Age: _____ Single Married Divorced
Social Security #: _____ Drivers License #: _____ Widowed Separated
Home Address: _____
Street City State Zip
Home Phone #: () _____ Work Phone #: () _____ Ext.: _____ Cell #: _____
Whom may we Thank for referring you? _____
Patient's Employer: _____ Occupation: _____
Employer's Address: _____
Street City State Zip
If patient is a student-Name of school: _____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #: () _____
Address: _____
Street City State Zip Work Phone #: () _____

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #: () _____
Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____
Billing Address: _____
Street City State Zip

Spouse/Parent Information

Name: _____ Birthday: ____ / ____ / ____ Social Security #: _____
Employer: _____ Work Phone #: () _____ Ext.: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: () _____ Group#: _____
Insurance Co. Address: _____
Street City State Zip
Insured's Name: _____ SS#: _____ Insured's Birthday: ____ / ____ / ____ Relation: _____
Insured's Employer: _____ Employer Address: _____
Street City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: () _____ Group#: _____
Insurance Co. Address: _____
Street City State Zip
Insured's Name: _____ SS#: _____ Insured's Birthday: ____ / ____ / ____ Relation: _____
Insured's Employer: _____ Employer Address: _____
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice. In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

Signature - Patient or Responsible Party _____ Date _____