

Welcome Welcome

Patient's Name _____
Last First Initial

Date _____ Date of Birth _____ () Male () Female

If Child: Parent's Name _____

How do you wish to be addressed _____
Single () Married () Separated () Divorced ()
Widowed () Minor ()

Residence _____
Street Apt. #

City _____ State _____ Zip _____

Employer _____

Business Address _____

Telephone: Res. _____ Bus. _____

Cell Phone # _____ Email _____

Patient/Parent Employed By _____

Present Position _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

Who is Responsible for this account _____

Address (if different from above) _____

Drivers License No. _____

Method of Payment: Insurance () Cash () Credit Card ()
Care Credit ()

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 _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____

Social Security No. _____

Employer Name _____

Name of Insurance Co. _____

Insurance Address _____

Insurance Telephone _____

Policy or Group # _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name _____

Social Security No. _____

Employer Name _____

Name of Insurance Co. _____

Insurance Address _____

Insurance Telephone _____

Policy or Group# _____

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, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

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

PATIENT OR GUARDIAN SIGNATURE: _____

DATE _____

PATIENT REGISTRATION