Vanover Dentistry of Orange Park
Implant - Family Care - Cosmetic

Patient Registration – Welcome to Our Office

About You

Today's Date: _____
Name: _____
Last First M. Dr. Mr. Mrs. Ms. Rev.
I prefer to be called: _____ ☐Male ☐Female
Birthday: ___/___/_____ Age: ____
SS#: _____-____-_____
Home Address: _____
_____Zip: _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: _____ Cell #: _____
E-mail: _____
Work #: _____ Ext: _____
Employer: _____
How Long There? _____ Occupation: _____

Who may we thank for referring you?
_____
Other family members seen by us:
_____

Previous/Present Dentist: _____
Last Visit Date: _____

What is your primary concern or reason for this appointment? _____
_____

Your Contact Preferences

Best way to be reached: (Please circle all that apply)
Home Ph | Work Ph | Cell Ph | Email | Text Message

Best way to be reminded of appointments:
Home Ph | Work Ph | Cell Ph | Email | Text Message

We do NOT share patient information with any other sources.

Dental Insurance

Insurance Co Name: _____
Insur. Co Phone#: _____
Policy Holder's (Subscriber) Information
Subscriber's Name: _____
Member/Subscriber's ID #:_____
Subscriber's SS#: ___ _____ - _____ - _____
Subscriber's DOB: ____/____/_____
Subscriber's Relation to Patient: _____
Subscriber's Employer: _____

Spouse Information

Spouse's Name: _____
Employer: _____
Work #: _____ Ext: _____
Birthday: ___/___/_____ Age: ____
SS#: _____-____-_____

Medical Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____
Relation to you: _____
Work#: _____ Home#: _____
Cell #: _____

I understand that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in strict confidence and that it is my responsibility to inform office of any changes in insurance, and/or medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I understand that payment for all treatment is ultimately my responsibility regardless of insurance coverage. I authorize the release of any information required to process my dental insurance and payment to be sent directly to this office. If this account is sent to collections, I agree to pay all associated costs incurred. Payment is due in full at time of treatment unless prior arrangements have been approved.

X _____
Signature Date