Patient Registration Form

Personal Information

Responsible Party _____
First Name Middle Initial Last Name

Patient _____
First Name Middle Initial Last Name

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Birthday _____ Social Security _____

Email Address _____

Emergency Contact

Name _____ Relation _____

Phone number _____ Phone number _____

Employer Information of Subscriber Insurance

Employer's Name _____ Phone number _____

Address _____

City _____ State _____ Zip _____

Full time student Yes ◯ No ◉ Where _____

Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)

Subscribers Name _____ Social Security _____ DOB _____

Insurance Company _____ Plan Name _____

Phone number _____ Address _____

City _____ State _____ Zip _____

Group Number _____ Policy Number _____

Payor ID/Number _____ Individual Deductible $_____

Individual yearly max $_____ Renewal date ____/____/_____

Secondary Insurance Information

Subscribers Name _____ Social Security _____

Insurance Company _____ Plan Name _____

Address _____

City _____ State _____ Zip _____

Group Number _____ Policy Number _____

Payor ID/Number _____ Individual Deductible _$_____

Individual yearly max _$_____ Renewal date ____/___/_____

Referral source

How did you hear about us?_____

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at time of service**.

If your insurance has not paid within 60 days from the date from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution

_____ _____

Date Signature of patient (responsible party of minor)

Use the button to the right to print your form once you have filled it out. >> **Print Form**