CLEMSON DENTAL

COSMETIC ◆ IMPLANT ◆ FAMILY DENTISTRY

Welcome!
Patient Registration

Name: _____Date of birth: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ Preferred contact method: Text Call Email
Address: _____ City: _____ State: ___ Zip: _____
SS#: _____ Marital status: _____
Employer: _____ Occupation: _____
Last dental exam? _____ Where? _____
How did you hear about us? _____

Insurance Information

Policy Holders Employer: _____ Occupation: _____
Insurance Company Name: _____ Phone: _____
ID #: _____
Person responsible for this account: _____ Relation to patient: _____
Date of birth: _____ SS #: _____
Address of different from patient: _____

Emergency contact: _____ Phone: _____ Relation: _____

If you could change anything about your smile, what would it be?

_____

I, the undersigned, certify that (the above-named patient) has insurance coverage with the above-named insurance company and assign these benefits directly to Clemson Dental, PA**. I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize Clemson Dental, PA to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

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CLEMSONDENTAL.COM