VITEK FAMILY DENTISTRY, P.C. ▪ ALEXA M. VITEK, D.D.S. ▪ 13173 SCHAVEY ROAD ▪ DEWITT, MI 48820 ▪ 517-277-2000

ADULT PATIENT REGISTRATION FORM

Welcome to our practice! We would like to sincerely thank you for selecting our team and we look forward to the opportunity to provide you with quality dental care. Please fill out this form completely & sign in ink.

PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____ M / F

Social Security #:_____ Birth Date:_____ Preferred Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Driver's License #:_____ Email:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Preferred Method of Contact *(please circle at least one)*: Cell Home Work Email Occupation:_____

May we contact you at work if needed? Y N May we send email correspondence regarding appointments? Y N

Employer:_____ Address: _____ Phone: _____

Marital Status *(please circle)*: Single Married Separated Divorced Widowed

In the event of an emergency, whom should we contact?

Name:_____ Relationship:_____ Phone #:_____

Whom may we thank for referring you?_____ Relation:_____

Other family members seen by our office: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

Insured's Name:_____ Relation:_____ Insured's Birth Date:_____

Insured's Social Security #:_____ Insured's Employer:_____

Insurance Company Name:_____ Insurance Company Phone #:_____

Insurance Group #:_____ Insurance Policy #:_____

SECONDARY DENTAL INSURANCE:

Insured's Name:_____ Relation:_____ Insured's Birth Date:_____

Insured's Social Security #:_____ Insured's Employer:_____

Insurance Company Name:_____ Insurance Company Phone #:_____

Insurance Group #:_____ Insurance Policy #:_____

AUTHORIZATION AND RELEASE

I authorize the dentist and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent. I authorize the dentist and staff to release any information including diagnosis and records of any treatment or examination rendered to third party payers and/or other health practitioners. I authorize and request my dental benefits company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for myself or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

_____ _____

PATIENT SIGNATURE **DATE**