PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____

City, State, Zip:_____

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

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #:_____

Responsible Party: (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address: _____

City, State, Zip:_____

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

Birth date:_____ Social Security #:_____

Someone to Notify in Case of Emergency:_____

Primary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Subscriber ID: _____ Group #:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Insurance Claim Address:_____ City, State, Zip:_____

Secondary Insurance Information:

Name of Insured:_____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Subscriber ID: _____ Group #:_____

Insured Social Security #: _____ Insured Birth date:_____

Employer:_____ Insurance Company:_____

Insurance Claim Address:_____ City, State, Zip:_____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper care. I consent to the dentist's disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. _____

_____

My consent to disclosure should be effective until I revoke in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less for the actual bill for services, and that I am financially responsible for my payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I atteste to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE:_____ DATE:_____