Patient Registration Information

Date _____(MM/DD/YY)

First Name _____ M.I. _____ Last Name _____ SS # _____

Home address _____ City_____ State _____ Zip _____

Birth date _____ DL # _____ Home Phone _____

E-Mail _____ Cell Phone _____

Are you: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Name of employer or school _____ Occupation _____

Spouse or parent/guardian's name Employer Work phone _____

Whom may we thank for referring you? _____

Responisble Party for Account

First Name _____M.I. _____Last Name _____SS # _____

Home address _____ City_____ State _____ Zip_____

Birth date_____ DL #_____ Home Phone _____

E-Mail _____ Cell Phone _____

Employer _____ Work Phone _____

Relationship to Patient _____ Is this person currently a patient in our office? □ Yes □ No

Insurance Information

Name of insured _____

Relationship to patient _____

Birth date _____ SS #_____ Date employed _____

Employer _____Work phone _____

Insurance company _____ Group # _____Ins. ID # _____

Ins. co. address _____City _____State _____ Zip _____

Ins. co. phone _____

How much Is your deductible? _____ How much have you used? _____Max. annual benefit? _____

Authorization, Release and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X _____

Signature of patient or parent/guardian If minor Date