



PATIENT REGISTRATION

Legal Name _____ DOB _____

Preferred Name _____

☐ Male ☐ Female ☐ Other _____

If the patient is a child, parent or guardian name:

Single ☐ Married ☐ Widowed ☐

HOME ADDRESS:

Street _____

City _____ State _____ Zip _____

Cell Phone (____) _____

Home Phone (____) _____

E-mail _____

Patient or Parent Employer (if currently employed):

Present Position: _____

Who is Responsible for this Account? _____

Driver's License No.

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card

Other family members in this practice:

Whom may we thank for this referral?

Patient Social Security No. _____

Emergency Contact: _____

Relationship to Patient: _____

Emergency Contact #: _____

DENTAL INSURANCE - PRIMARY

Subscriber's Name _____ DOB _____

Relationship to Patient _____

Insurance Co. _____

Insurance Co. Telephone _____

Group # _____

Identification #: _____

DENTAL INSURANCE - SECONDARY

Subscriber's Name _____ DOB _____

Relationship to Patient _____

Insurance Co. _____

Insurance Co. Telephone _____

Group # _____

Identification #: _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and 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.

My consent to disclosure of records shall be effective until I revoke it 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 than the actual bill for services, and that I am financially responsible for 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 attest to the accuracy of the information on this page:

PATIENT OR GUARDIAN'S SIGNATURE

DATE