PATIENT NUMBER

PATIENT'S NAME _____ Date_____ Date of Birth _____ ☐ M ☐ F
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED_____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

ADDRESS _____

CITY_____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

PHONE: RES._____ BUS._____

PATIENT EMPLOYED BY _____

PRESENT POSITION _____

SPOUSE NAME _____

SPOUSE EMPLOYED BY_____

PRESENT POSITION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE NO._____

METHOD OF PAYMENT:

Insurance ☐ Credit Card ☐ Cash ☐

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT SS # _____

SPOUSE/PARENT SS # _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU_____

_____

DENTAL INSURANCE COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

NAME OF INSURANCE _____

ADDRESS _____

_____

TELEPHONE _____

PROGRAM OR POLICY# _____

SOCIAL SECURITY NO. _____

OFFICE USE ONLY

	DATE	FREQ
EXAM		
PANO		
BWX		
PROPHY		
FLUORIDE		
PERIO HX		
SEALANTS		

DEDUCTIBLE _____ MAX _____

PREV _____ PERIO _____

BASIC _____ ENDO _____

MAJOR _____ EXTR _____

EFF DATE _____ RENEW_____

RELEASE

I authorize the dentist and all staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, 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. I understand I am financially responsible for payments 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, in whole or in part by my dental care payor.

I hereby agree to pay all costs of collection (including attorney fees), should any amount due hereunder be turned over for collection.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION

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