

Welcome

PATIENT REGISTRATION

Patient's Name _____ **Date of Birth** _____ **Male** **Female**
Last First Initial

If child, Parent's Name: _____

How do you wish to be addressed: _____
Single Married Separated Divorced Widowed Minor

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone Res. _____ Bus. _____

Fax _____ Cell Phone _____

Email _____

Patient/Parent Employed By _____

Present Position _____ How Long Held _____

Spouse Employed By _____

Present Position _____ How Long _____

Who is Responsible for this Account _____

Drivers License No. _____

Method of Payment: Insurance Cash Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency (not living with you):

Dental Insurance - 1st COVERAGE

Employee Name _____

Date of Birth _____ Relationship to patient _____

Employer Name _____

Name of Insurance Co. _____

Address _____

Telephone _____

Policy # _____

Social Security No. _____

Union Local or Group No. _____

Dental Insurance - 2nd COVERAGE

Employee Name _____

Date of Birth _____ Relationship to patient _____

Employer Name _____

Name of Insurance Co. _____

Address _____

Telephone _____

Policy # _____

Social Security No. _____

Union Local or Group No. _____

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. *I consent* to the 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 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'S OR GUARDIAN'S SIGNATURE DATE

...providing exceptional gentle personalized care!