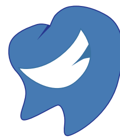

PATIENT REGISTRATION

Date: ________________________

Full Name: ____ Sex: ☐ M ☐ F DOB: _____ /_____ /_____

Address: ____ City, Zip: ________________________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

Email: ______________________________ Driver's License #: ____________________ State: ____ Exp: _________

Employer/School (If Student): ______________________________________ Phone: ______________________

Nearest Relative Not Living With You: ______________________________ Phone: ______________________

Emergency Contact Name: ______________________________________ Phone: ______________________

Whom May We Thank For Referring You To Us: ____

RESPONSIBLE PARTY

Person Responsible For Account: ______________________________ Relationship: ______________________

Mailing Address: ______________________________ Phone: ____________________ DOB: ___ /___ /___

Driver's License #: ____________________ Employer: ______________________________ Phone: ______________________

INSURANCE INFORMATION

Subscriber Name: ______________________________ DOB: ___ /___ /___ ID/SSN: ____________________

Employer: ______________________________ Phone: ____________________ Group #: ____________________

Insurance Co: ______________________ Address: ______________________________ Phone: ____________________

Relationship to Patient: ______________________________

SECONDARY INSURANCE INFORMATION

Subscriber Name: ______________________________ DOB: ___ /___ /___ ID/SSN: ____________________

Employer: ______________________________ Phone: ____________________ Group #: ____________________

Insurance Co: ______________________ Address: ______________________________ Phone: ____________________

Relationship to Patient: ______________________________

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Check ☐ Credit Card ☐ Care Credit

I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand as a courtesy, this office will help prepare my insurance forms to assist in making collection from insurance companies and will credit such collections to my account. We will do our best to provide an estimate of insurance payment, but cannot render services on the assumption that charges will be paid by the insurance company.
Assignment of Insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: ______________________________________ Date: __________________________