Confidential

Patient Registration Information

Patient Information:

Date: _______________

Patient's Name: ____
Last First M.I. Preferred

Address: ____ City: ____________________ Zip:________________

Home Phone: (____)______--_______ Cell Phone: (____)_____--______ Email: __________________________________

Sex: □ Male □ Female DOB: ___________ Social Security #:______________

If Patient is a minor, give Parent or Guardian's name: ____

How did you hear of us? □ Internet □ Insurance Co. □ Patient, who?__________________ □ Other:_________________

Employer: ____________________ Occupation: _________________________ No. Years Employed: ______________

Responsible Party is also Policy Holder □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Responsible Party: (If other than patient)

Responsible Party Name: ____
Last First M.I.

Address: ____ City: ____________________ Zip:________________

Phone: (____)______--_______ DOB: ______________ Social Security #: ______________

Relationship to Patient: __________________________________

□ Responsible Party is also Policy Holder □ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Insurance Information

Name of Subscriber: _________________________________ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Subscriber's Insurance ID or Social Security #: ___________________________ Subscriber's DOB: ______________

Insurance Company: ___________________________________ Group #.: ___________________________

Insurance Co. Address: ____ Phone: _________________________

Does the Patient have dual coverage? □ Yes □ No If yes, please complete the following:

Name of Subscriber: _________________________________ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Subscriber's Social Security #: _________________ Subscriber's DOB: _______________ Subscriber ID: _________________

Insurance Company: ___________________________________ Group No./Local No.: ____________________________

Insurance Co. Address: ____ Phone: _________________________

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____ Date: __________________