

\_\_\_\_\_

PATIENT NUMBER

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

RESIDENCE - STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE: RES. \_\_\_\_\_ BUS. \_\_\_\_\_ CELL \_\_\_\_\_

PATIENT/PARENT EMPLOYED BY \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_

PATIENT/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

SPOUSE/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_

OTHER FAMILY MEMBERS IN THIS PRACTICE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL \_\_\_\_\_

\_\_\_\_\_

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU \_\_\_\_\_

**FINANCIAL INFORMATION**

WHO IS RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

DRIVERS LICENSE NO. \_\_\_\_\_

METHOD OF PAYMENT: Credit Card  Cash

CARD NO: \_\_\_\_\_ Expires \_\_\_\_\_

Type of Card: MC / VISA / DISC / AMEX

\_\_\_\_\_  
Cardholder Signature

**I am aware that I must pay my estimated portion due the same day I see the doctor unless I have left a valid credit card on file.**

**DENTAL INSURANCE 1ST COVERAGE**

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE SOCIAL SECURITY NO. \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY OR GROUP # \_\_\_\_\_

**DENTAL INSURANCE 2ND COVERAGE**

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE SOCIAL SECURITY NO. \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

TELEPHONE \_\_\_\_\_

POLICY OR GROUP # \_\_\_\_\_

I authorize the dentist 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 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 guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance, at the rate of eighteen percent (18%) per annum, will be accrued 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection fees incurred.

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

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**REGISTRATION**