PATIENT REGISTRATION

PATIENT'S
NAME_____

IF CHILD, PARENT OR
GUARDIAN NAME_____

HOW DO YOU WISH TO BE
ADDRESSED? _____

SINGLE MARRIED

ADDRESS-STREET_____

CITY_____STATE____ZIP_____

PATIENT/PARENT EMPLOYED BY_____

TELEPHONE: RES_____BUS_____

BEST TIME/PLACE TO CALL YOU _____

PRESENT POSITION_____HOW LONG HELD?_____

OTHER FAMILY MEMBERS IN THE PRACTICE_____

WHO MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SS#_____

SPOUSE/PARENT SS#_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY

_____

WHAT ARE YOUR HOBBIES/INTERESTS? _____

EMAIL _____

DATE OF BIRTH_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____

NAME OF INS CO. _____

ADDRESS _____

_____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY # _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

NAME OF INS CO _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY # _____

I authorize the dentist to perform diagnostic procedures and treatment as may be needed for proper dental care.
I authorize release of any information concerning my (or my children'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 and treatment to another dentist.
I understand that I am responsible for all costs of dental treatment and I agree to pay 12% interest on any balance over 60 days.
24 hour notice is needed for changed appointments.
I authorize credit information to be checked.

PATIENT'S OR GUARDIAN'S
SIGNATURE_____DATE_____