Account #

Welcome

Patient' Name _____
Last First Initial

Date _____ Date of Birth _____ ☐ Male ☐ Female

If Child: Parent's Name_____

How do you wish to be addressed_____

Single ☐ Married ☐ Separated ☐ Widowed ☐ Minor ☐

Residence-Street_____

City_____State_____Zip_____

Business Address_____

Telephone: Res._____

Fax_____Cell Phone_____

eMail_____

Patient/Parent Employed By_____

Present Position_____

How Long Held_____

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 referal_____

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_____
Employer Name_____Yrs._____
Name of Insurance Co._____
Address_____
_____
Telephone_____
Program or Policy#_____
Social Security No._____
Union local or Group_____

DENTAL INSURANCE 2ND COVERAGE

Employee Name_____Date of Birth_____
Employer Name_____Yrs._____
Name of Insurance Co._____
Address_____
_____
Telephone_____
Program or Policy #_____
Social Security Number_____
Union Local or Group_____

RELEASE:

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 understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in the full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment in full at the time the services are provided. My insurance carrier will re-imburse me directly.

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

PATIENTS OR GAURDIAN'S SIGNATURE

_____

DATE_____

New Patient Registration