

**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 referral \_\_\_\_\_

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**