Patient Registration Information

(Confidential)

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Patient Information

Date _____

Patient _____ Preferred: _____ Sex: ❑ M ❑ F

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____ Cell # _____

Birth date _____ Patient SS# _____ ❑ Single ❑ Married ❑ Widowed

If college student, F.T. / P.T., Name of School _____ City _____ State/Prov._____

If a minor, give parent's or Guardian's Name _____ Phone # _____

How can we confirm appointments with you? Home Work Cell Text Email _____

How did you hear about our office? _____

In case of an emergency, who should be notified? _____ Phone # _____

Responsible Person(s) for the Account Financially

Name of person
responsible for this account _____ Relationship to patient _____

Address _____ City _____ State Zip _____

Home Phone # _____ Work # _____ Cell # _____

Driver's License # _____ State Issued _____

Employer _____

Birth date _____ SS# _____

I have read the above regarding financial responsibility of the account and agree with its content.

Signature: _____ Date: _____

Dental Insurance

Primary Insurance

Subscriber's Name _____ Date of Birth _____

Subscriber's SS #/ID# _____ Subscriber's Employer _____

Insurance Co. Name _____ Group # _____

Insurance Co. Phone # _____

Secondary Insurance

Subscriber's Name _____ Date of Birth _____

Subscriber's SS #/ID# _____ Subscriber's Employer _____

Insurance Co. Name _____ Group # _____

Insurance Co. Phone # _____

I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that having dental insurance is not a guarantee of payment for services rendered and that all fees are an arrangement between me and this office and not between the office and the insurance company.
I am aware that the office will prepare the patients insurance forms as a courtesy and/or assist in making collections from insurance companies and will credit any such collections to the patient's account.

I have read the above regarding dental insurance and my responsibilities and agree with its content.

Signature: _____ Date: _____