PATIENT REGISTRATION

Patient Information

First Name _____ Last Name _____ M.I. ____

Preferred Name _____ Patient is □ Responsible Party □ Policy Holder

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

I would like to receive: □ text messages □ email correspondences email: _____

○ Female ○ Male ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed Student: ○Full Time ○ Part Time

Birth Date _____ Social Security _____-____-_____ Drivers License # _____

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

How did you learn about us? _____Whom may we thank? _____

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ M.I. ____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

Birth Date _____Social Security _____-_____-_____ Drivers License # _____

○ Responsible Party is Primary Policy Holder for Patient ○ Secondary Policy Holder

Primary Insurance Information:

Insured Name: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer: _____ Group # _____

Insured Birth Date: _____ Insured SS or ID _____

Secondary Insurance Information:

Insured Name: _____ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer: _____ Group # _____

Insured Birth Date: _____ Insured SS or ID _____

Authorization and Release

I certify that the above information to the best of my knowledge is accurate. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date