REGISTRATION FORM

Today's date:	Chart Number:

PATIENT INFORMATION

Patients full name:	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

(Preferred Name):	SSN:	Birthdate: / /	Age:	Sex: ❑ M ❑ F

Street address:	Drivers license number:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

E-mail address:	Cell phone no.: ( )

Occupation:	Employer:	Employer phone no.: ( )

If full time student, school name:

Name of person responsible for this account:

Whom may we thank for referring you to our office?

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insured Person:

Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer phone no.: ( )

Employer address:

Name of primary insurance:

Subscriber's name:	Subscriber's SSN:	Birthdate: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's SSN:	Birthdate: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	

AUTHORIZATION

I hereby authorize payment directly to Diamond Dental Studio all insure benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize Diamond Dental Studio to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/pr other health professionals.

Patient/Guardian signature:	*Date:*