Welcome

Thank you for selecting Jasmine Dental Care! We will strive to provide you with the best possible dental care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any question or need assistance, please ask us and we'll be happy to help.

Patient Information (CONFIDENTIAL)

*Soc. Sec. #*____________________

Name ____________________ *Birth Date* __________ *Home Phone* ( ) __________

Address ____________________ *City* __________ *State* ______ *Zip* ______

Email Address ____________________

Check Appropriate Box ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

If Student, Name of School/College ____________________ ☐ *Full Time* ☐ *Part Time*

Patient's or Parent's Employer ____________________ *Work Phone* ( ) __________

Business Address ____________________ *City* __________ *State* ______ *Zip* ______

Spouse or Parent's Name ____________________ *Employer* __________ *Work Phone* ( ) __________

Whom May We Thank for Referring You? ____________________

Person to Contact in Case of Emergency ____________________ *Phone* ( ) __________

Person Responsible for This Account – Please Check One: *Patient* *Guardian* *Spouse* *Father* *Mother*

Insurance Information

Primary insured	***Secondary Insured***
Last *First* *M*	*Last* *First* *M*
Street *City* *State* *Zip*	*Street* *City* *State* *Zip*
Home# *Work#* *Fax#*	*Home#* *Work#* *Fax#*
Birth Date *Relationship to Patient*	*Birth Date* *Relationship to Patient*
Employer *Dental Ins. Co*	*Employer* *Dental Ins. Co*
SS# *Subscriber#* *Group#*	*SS#* *Subscriber#* *Group#*

Method of Payment

For your convenience, we offer the following methods of payment. Please check the option you prefer. ***Payment in Full at each appointment***

☐ *Cash* ☐ *Personal check* ☐ *Credit Card* ☐ *Visa* ☐ *Mastercard* ☐ *Discover* ☐ *American Express*

☐ *I wish to discuss the office's finance policy*

Authorization

I hereby authorize payment directly to Jasmine Dental Care of the group insurance benefits otherwise payable to me. I understand that I am responsible to all costs of dental treatment. I hereby authorize the Dental office 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 /or other health professionals.

____

Patient or Responsible Party ***Date*** ***State Driver's License***

PATIENT REGISTRATION FORM