REGISTRATION

PATIENT

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cellular _____

Preferred Name _____ ___ Male ___ Female ___Married ___Single ___Divorced ___ Separated ___ Widowed

Birth Date _____ Age _____ Soc Sec # _____ Driver's License # _____

Email Address_____ Would you like to receive appointment reminders via email? _____

Employment Status: ____ Full Time ____ Part Time ____Retired College Student Status: ____Full Time ____ Part Time

Name and Address of Employer: _____

Name and Address of College: _____

Spouse's Name _____Soc Sec # _____ Birth Date _____

If spouse employed, Name and Address of Employer _____

Do you have any immediate dental problems? _____

When was your last visit for dental care and what was done? _____

Name and Address of you previous dentist _____

If Patient is a Child or Dependent, Names and Addresses of Parents or Guardians:

Parent/Guardian #1 _____Address _____ Phone _____

Parent/Guardian #2 _____ Address _____Phone_____

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (financial)

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Work Phone _____ Ext _____ Cellular _____

Birth Date _____ Age _____ Soc Sec # _____ Driver's License # _____

Employer Name and Address _____ Relationship to Patient _____

PRIMARY DENTAL INSURANCE (if any)

Name of Insured _____ Birth Date _____ Soc Sec # _____

Patient's Relationship to Insured: ____ Self ____ Spouse ____ Child _____Other (explain) _____

Employer Name and Address _____

Name of Insurance Company _____ **Please provide us with your insurance card for scanning.**

SECONDARY INSURANCE (if any)

Name of Insured _____ Birth Date _____ Soc Sec # _____

Patient's Relationship to Insured: ____ Self ____ Spouse ____ Child _____Other (explain) _____

Employer Name and Address _____

Name of Insurance Company _____ **Please provide us with your insurance card for scanning.**

I certify that the information above is true and correct to the best of my knowledge and belief. I authorize my insurance company to pay directly to the dentist's office, insurance benefits otherwise payable to me. I understand I am responsible for all co-pays, deductibles, co-insurance balances. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances.

Signed _____ Date _____

We truly appreciate referrals to our practice. Is there anyone we might thank for referring you to our office?

Name and Address _____

If there is anything we can do to make your visits more comfortable, please do not hesitate to tell us. Thank you for choosing our office!