Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

First Name _____Middle Initial _____Last_____ SSN#_____
Address _____ City _____State____ Zip_____
Cell Phone _____Home Phone _____ Email_____
Sex M __F __ Age____ Date of Birth _____Single___ Married ___Widowed ___ Separated___ Divorced___
Employer _____Occupation _____
Employer Address _____ Business phone _____
Notify in case of Emergency _____Cell Phone_____
Business Phone _____ Home Phone_____
Whom may we thank for referring you?_____
Preferred Dentist_____ Preferred Hygienist _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Relation to Patient _____ Date of Birth _____ SSN#_____
Address (if different that patient) _____ City _____ State _____ Zip _____
Cell phone_____ Business phone_____ Email _____
Employer _____ Occupation _____
Business Address _____
DENTAL Insurance Company_____ Phone _____
DENTAL Insurance Company Address_____
Subscriber ID # _____ Group #_____

SECONDARY DENTAL INSURANCE

Is patient covered by additional DENTAL insurance? Yes __ No __
Subscriber Name _____
Relation to Patient _____ Date of Birth _____ SSN#_____
Address (if different that patient) _____City _____ State _____ Zip _____
Cell phone_____ Business phone_____ Email _____
Employer _____ Occupation _____
Business Address _____
DENTAL Insurance Company_____ Phone _____
DENTAL Insurance Company Address_____
Subscriber ID # _____ Group #_____

AUTHORIZATION

I have reviewed the information on this registration form and it is accurate to the best of my knowledge.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance claim submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand I am financially responsible for all charges not paid by the insurance company.

Signature_____Date_____