PATIENT REGISTRATION

Patient's name____
Last First Middle

Preferred name_______________________________ Birth date______________________________

SOC SEC_____________ Driver's license_______________________ email__________________

Patient is _____male ______female ______married _____single_____divorced_____separated_____widowed

Mailing address____
____
City state zip

Cell phone__________________ Work phone____________________ home phone___________________

Name of responsible party____
Last First middle

Responsible party social security number____

Primary Insurance Information

Insured Name___________________________________ Birth Date__________________________________

SOC SEC #____

Employer____ Insurance Company________________________

Group___________________________ Subscriber ID #____

Secondary Insurance Information

Insured Name______________________________________ Birth date________________________________

Social Security #_________________________ Employer___________________ Ins. Co_________________

Subscriber ID #____

HOW DID YOU HEAR ABOUT OUR OFFICE?____

Who may we notify in case of an emergency?

Name_____________________________________ Telephone #____

RELEASE:

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I understand delivery of local anesthetic may have side effects which can include but are not limited to temporary or permanent numbness, hematoma, or cardiac stimulation. I understand that occasionally needles break and may require surgical removal.
- I authorize release of any information concerning my (or my child's) healthcare, advise, and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) healthcare, advise, and treatment to another dentist.
- I understand that I am responsible for payment for all cost of dental treatment as my insurance may pay less than the actual bill. I understand that all original records are the property of the dentist
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand the dental office reserves the right to charge for missed appointments.
- I authorize the dentist to take photographs for diagnostic procedures and for educational purposes.
- Any and all costs of collection of an outstanding balance on your account will be paid by the patient
- I attest to the fact that I have read and understand the above and attest to the accuracy of the information on this page.

Patient's or guardian's signature____ Date_________________