PATIENT REGISTRATION INFORMATION

Patient Name:________________________________ Date of Birth:___________ Soc Sec # _____________

Home address: ______________________________________City/State/Zip__________________________

Home Phone:__________________ Cell Phone:___________________ Work Phone:_________________

Email: ____

Emergency Contact Name ________________________Number: _____________ Relationship_________

How did you find our office? □ Friend / Family (please write name __________________________________)

□ Street Sign □ Internet □ Radio □ Facebook □ Received something in mail □ Insurance list of providers

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Work Information (if patient is a child or minor, put parents information in this section)

Employer:____________________________________ Occupation:__________________________________

Work address: ____City/State/Zip_________________________

Responsible Party (usually yourself, if you are an adult. For children, list the parent or adult responsible for the child)

Name:________________________________ Date of Birth:___________ Soc Sec # __________________

Home address: ______________________________________City/State/Zip_________________________

Home Phone:_________________ Cell Phone:___________________ Work Phone:_________________

Insurance Information

Named of Insured: :____________________________ Date of Birth:________ Soc. Sec # _____________

Relationship to Patient: __________ Employer that the insurance is through: ________________________

Insurance Company: _________________________Member ID #: __________________________

Group#:___________________

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist or the dental office, insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X____ ______________________

Signature of patient or parent if minor Date