We are pleased to welcome you to our office. 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.

PATIENT REGISTRATION

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone_____ Cell Phone_____ Cell Phone Carrier_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ]CELL [ ] Email

Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ]CELL [ ] Email

Preferred contact method for recall [ ] HmPhone [ ] WkPhone [ ]CELL [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Part-time

How did you hear about us?

_____

Please let us know how you heard about us: if it was a family member or other patient, we'd like to thank them.

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

DOES INSURANCE POLICY HOLDER HAVE A DIFFERENT ADDRESS THAN PATIENT? **If yes, please complete:**

Address_____ City_____State____ Zip_____

DENTAL INSURANCE POLICY: PRIMARY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card and Driver's License (or other State or Federal Picture ID) to Office Manager.

DENTAL INSURANCE POLICY: SECONDARY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

EMERGENCY CONTACT: (Nearest person **not** living at same address)

Name:_____ Relationship:_____

Address: _____City_____ State____ Zip_____

Home Phone:_____ Cell Phone:_____ email:_____

AUTHORIZATION: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice, and treatment provide for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist when necessary.

I hereby authorize payment of insurance benefits directly to the dentist or his assigned, otherwise payable to me.
I attest to the accuracy of the information on this page, and will inform the dental office if there are any changes in the future.

_____ ___/___/___

Signature of Patient (or legal guardian if under 18) Date