REGISTRATION

PATIENT'S NAME _____ Today's Date _____ Patient's Date of Birth _____
Last First Initial

PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED? _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

RESIDENCE- STREET _____

CITY _____ STATE_____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE RES: _____ BUS._____

CELL: _____ Email: _____

RECEIVE REMINDERS VIA EMIAL: Yes ☐ No ☐

RECEIVE APPOINTMENT REMINDERS VIA TEXT: Yes ☐ No ☐

PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/OTHER PARENT NAME_____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

PURPOSE OF VISIT _____

OTHER FAMILY MEMBERS IN PRACTICE_____

_____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING IN SAME HOUSEHOLD)_____

_____

DENTAL INSURANCE 1ST COVERAGE

SUBSCRIBER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S SS# _____

SUBSCRIBER'S INSURANCE ID#_____

EMPLOYER _____# YRS_____

NAME OF INSURANCE CO. _____

INS. CO. BILLING ADDRESS_____

INS. CO. PH# _____

GROUP OR POLICY # _____

UNION LOCAL OR GROUP NAME_____

DENTAL INSURANCE 2ND COVERAGE

SUBSCRIBER'S NAME_____

SUBSCRIBER'S DATE OF BIRTH_____

SUBSCRIBER'S SS#_____

SUBSCRIBER'S INSURANCE ID#_____

EMPLOYER_____#YRS_____

NAME OF INSURANCE CO._____

INS. CO. BILLING ADDRESS_____

INS. CO. PH#_____

GROUP OR POLICY #_____

UNION LOCAL OR GROUP NAME_____

RELEASE:

1. I acknowledge that the above information is accurate.
2. I understand that all fees not covered by insurance are due on the day of service.
3. I authorize my insurance company to pay directly to the dentist.
4. I understand the by signing below that I am responsible for charges for all consented treatment.

Responsible Party _____ Date_____

PRIVACY STATEMENT:

1. I give permission to the doctors and the staff to disseminate health information to other health care providers that are also involved with the patient's care.
2. I have received the practice privacy statement.

Legal Guardian _____ Date _____