

# REGISTRATION

(CONFIDENTIAL)

DATE \_\_\_\_\_

PATIENT'S NAME (Last) _____			(First) _____			(Middle) _____		
AGE _____	D.O.B. _____	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	
ADDRESS _____			CITY, STATE _____			ZIP _____		
HOME PHONE _____		CELL PHONE _____		E-MAIL: _____				
PATIENT'S EMPLOYER _____			ADDRESS _____			WORK PHONE _____		
SS # _____ / _____ / _____		DRIVER'S LIC. # _____		OCCUPATION _____				
SPOUSE'S NAME _____		D.O.B. _____		SS # _____ / _____ / _____				
SPOUSE'S EMPLOYER _____			ADDRESS _____			WORK PHONE _____		

PLEASE FILL OUT  
IF THE PATIENT IS A MINOR (UNDER AGE 18) OR FULL-TIME STUDENT

MOTHER'S NAME _____		ADDRESS _____		D.O.B. _____		HOME PHONE _____	
MOTHER'S EMPLOYER _____		ADDRESS _____				WORK PHONE _____	
SS # _____ / _____ / _____		DRIVER'S LIC. # _____		OCCUPATION _____			
FATHER'S NAME _____		ADDRESS _____		D.O.B. _____		HOME PHONE _____	
FATHER'S EMPLOYER _____		ADDRESS _____				WORK PHONE _____	
OCCUPATION _____		PRESENT POSITION _____		HOW LONG EMPLOYED _____		SS # _____ / _____ / _____	
STUDENT'S SCHOOL NAME(S) _____							

## PERSON RESPONSIBLE FOR PAYMENT

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

D.O.B. \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SS # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DRIVER'S LIC. # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

I WILL PAY FOR DENTAL SERVICES TODAY AS FOLLOWS (CHECK PREFERENCE):

CASH     CHECK     CREDIT CARD

\_\_\_\_\_  
RESPONSIBLE PARTY'S SIGNATURE

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED (PERSON NOT LIVING WITH YOU)

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

(Continued on Back)

## DENTAL INSURANCE INFORMATION

INSURANCE CO. (PRIMARY) NAME	INSURED	EFFECTIVE DATE
ADDRESS	PHONE NUMBER	GROUP NUMBER
INSURANCE CO. (SECONDARY) NAME	INSURED	EFFECTIVE DATE
ADDRESS	PHONE NUMBER	GROUP NUMBER

### ACKNOWLEDGEMENT & AUTHORITY

All professional services rendered are charged to the patient. It is our office policy to bill your insurance carrier as a courtesy to you, although the patient is responsible for all fees regardless of insurance coverage. The range of benefits depends solely on what the employer who purchases the plan wishes to offer employees or members. For example, if your plan states that it will pay 80% of the cost of dental treatment, it means 80% of the fee as determined by the insurance company, and not necessarily the actual fee charged by the dentist. To expedite processing, we ask that you provide complete and accurate insurance information to our Business Office and advise us of any carrier or coverage changes when they occur.

### ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid to the undersigned dentist, and I am financially responsible for all non-covered services. I also authorize the doctor to release any medical or health related information required to process my insurance claim.

\_\_\_\_\_  
INSURED, Signature