PATIENT REGISTRATION

Patient Information:

First Name:_____Last Name_____Middle Initial:_____

Address:_____

City:_____ State_____ Zipcode_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Sex:_____Male_____Female Marital Status:_____Married _____Single _____Divorced _____Separated _____Widowed

Birth Date:_____ Age:_____ Social Security:_____

Email:_____

Responsible Party (if someone other than the patient):

First Name:_____Last Name_____Middle Initial:_____

Address:_____

City:_____ State_____ Zipcode_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Sex:_____Male_____Female Birth Date:_____ Social Security:_____

Primary DENTAL Insurance Information:

Name of Policy Holder:_____Relationship to Insured:_____Self _____Spouse _____ Child ____Other

Policy Holder Social Security_____Insured Date of Birth_____

Employer:_____

Employer Address:_____

Insurance Company:_____

ID#:_____Group#:_____

Secondary DENTAL Insurance Information:

Name of Policy Holder:_____Relationship to Insured:_____Self _____Spouse _____ Child ____Other

Policy Holder Social Security_____Insured Date of Birth_____

Employer:_____

Employer Address:_____

Insurance Company:_____

ID#:_____Group#:_____

Please read, sign and date the following:

I hereby authorize release of any information regarding my (or my child's) dental treatment requested by my insurance company/companies **if and when** I have dental insurance. If my insurance makes payment directly to the dentist, I hereby authorize this.

_____ _____

Signature of Responsible Party Date