Patients Name_____**Today's Date**_____
Last First Initial Date of Birth

If Child:
Parents Name_____
Last First Initial

How do you wish to be addressed_____

Single___Married____Separated____Divorced____Widowed____Minor___

Residence – Street_____

City_____ State_____Zip_____

Home Phone:_____Work:_____

Cell Phone:_____

E-mail Address_____

Patient/Parent Employed by_____

Present Position_____How Long Held?_____

Spouse/Parent Name_____

Spouse Employed By_____

Present Position_____How Long Held? _____

Who is Responsible for this account? _____

Method of Payment: Insurance___Credit Card___Cash___

Purpose of Call_____

Other Family Members in This Practice_____

Whom May We Thank For This Referral?

_____

Patient/Parent Social Security No._____

Spouse/Parent Social Security No._____

DENTAL INSURANCE 1ST COVERAGE

Employee Name_____

Employee Date of Birth_____

Employer_____# Yrs_____

Name of Insurance Co._____

Address_____

_____

Telephone_____

Program or Policy #_____

Union Local or Group_____

Social Security No._____

DENTAL INSURANCE 2ND COVERAGE

Employee Name_____

Employee Date of Birth_____

Employer_____# Yrs_____

Name of Insurance Co._____

Address_____

_____

Telephone_____

Program or Policy #_____

Union Local or Group_____

Social Security No._____

Name and Phone Number of Someone to Notify in Case of Emergency (Not Living with You)_____

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 provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment and I agree to pay 12% interest on any balance over 60 days.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

24-hour notice must be given to avoid a broken appointment charge.

If the insurance company sends payment directly to you, it is your responsibility to forward payment in full to our office within 10 days

I authorize credit information to be checked.

PATIENT'S OR GUARDIAN'S SIGNATURE_____**DATE**_____

REGISTRATION