PATIENT REGISTRATION

PATIENT LAST NAME: _____ **FIRST:** _____ **INITIAL:** _____

How do you wish to be addressed? _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Telephone (Mobile) _____ (Work) _____ (Home) _____

Email _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Subscriber Name _____	Subscriber Name _____
Subscriber ID _____	Subscriber ID _____
Date of Birth _____	Date of Birth _____
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____
Insurance Company _____	Insurance Company _____
Insurance Group _____	Insurance Group _____
Insurance Phone _____	Insurance Phone _____

Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY *(If minor)*

Last Name: _____ First: _____ Initial:

Address *(If different)* _____ Date of Birth _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

EMERGENCY CONTACT

Last Name: _____ First: _____ Initial:

Telephone (☐Mobile ☐Work ☐Home) _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

(Responsible Party, if under 18)