REGISTRATION

PATIENT

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cellular _____

Preferred Name _____ ___ Male ___ Female ___ Married ___ Single ___ Divorced ___ Separated ___ Widowed

Birth Date _____ Age _____ Soc Sec # _____ Driver's License # _____

Email Address _____ Would you like to receive correspondences via email? _____

Employment Status: ___ Full Time ___ Part Time ___ Retired College Student Status: ___ Full Time ___ Part Time

Name and Address of Employer _____

Name and Address of College _____

Spouse's Name _____ Soc Sec # _____ Birth Date _____

If spouse employed, Name and Address of Employer _____

Do you have any immediate dental problems? _____

When was your last visit for dental care and what was done? _____

Name and Address of your previous dentist _____

If Patient is a Child or Dependant, Names and Addresses of Parents or Guardians:

Parent/Guardian #1 _____ Address _____ Phone _____

Parent/Guardian #2 _____ Address _____ Phone _____

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (financial)

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____ Cellular _____

Birth Date _____ Age _____ Soc Sec # _____ Driver's License # _____

Employer Name and Address _____ Relationship to Patient _____

PRIMARY INSURANCE INFORMATION (if any)

Name of Insured _____ Birth Date _____ Soc Sec # _____

Patient's Relationship to Insured: ____ Self ____ Spouse ____ Child ____ Other (explain) _____

Employer Name and Address _____

Name of Insurance Company _____ **Please provide us with your insurance card for scanning.**

SECONDARY INSURANCE INFORMATION (if any)

Name of Insured _____ Birth Date _____ Soc Sec # _____

Patient's Relationship to Insured: ____ Self ____ Spouse ____ Child ____ Other (explain) _____

Employer Name and Address _____

Name of Insurance Company _____ **Please provide us with your insurance card for scanning.**

Is there anything else you would like us to know, such as past dental treatment experiences, etc? _____

I certify that the information above is true and correct to the best of my knowledge and belief. I authorize my insurance company to pay directly to the dentist's office, insurance benefits otherwise payable to me. I understand I am responsible for all co-pays, deductibles, co-insurance and balances. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. Signed _____ Date_____

We truly appreciate referrals to our practice. Is there anyone we might thank for referring you to our office?

Name and Address _____

If there is anything we can do to make your visits more comfortable, please do not hesitate to tell us. Thank you for choosing our office!