DATE: _____

PATIENT REGISTRATION

PATIENT INFORMATION

Name:_____ Birth Date: _____ Social Security #:_____

Address: _____ City: _____ State: ____ Zip Code:_____

Please prioritize preference for how you would like to be contacted by numbering the following 1, 2, 3, 4 on the left:

Single ❒ Married ❒ Divorced ❒ Widowed ❒

____ Home Phone: _____

____ Work Phone: _____ Spouse's Name: _____ And SS#:_____

____ Mobile Phone: _____ If Child, Parent's Name (or custodial parent/guardian): _____

____ Email Address: _____ Parent Name Not Living in the Home: _____

Employer Name: _____ Employer Address: _____

Occupation:_____ Referred to Us by: _____

In case of an emergency, contact (Name, Address, Phone):

_____

_____

Closest relative not living with you (Name, Address, Phone):

_____

_____

Is another member of your family or relative a patient at our office? If yes, their name: _____

PERSON FINANCIALLY RESPONSIBLE

Please fill out this section only if person financially responsible is different from the patient.

Name/Spouse's Name: _____ Occupation: _____

Address: _____ City: _____ State: ____ Zip Code:_____

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Social Security Number: _____ Spouse's SS#: _____

IF YOU DO NOT HAVE DENTAL INSURANCE, PLEASE INDICATE WITH AN X ❒

DENTAL INSURANCE

PRIMARY DENTAL CARRIER

Subscriber Name: _____ Subscriber ID or Social Security Number: _____

Subscriber Birth Date: _____ Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ Group or Local Number: _____

Please fill in employer name, address, phone number and occupation below *only* if it is different than listed above under Patient Information.

Employer Name: _____ Employer Address:_____

Employer's Phone Number: _____ Occupation:_____

SECONDARY DENTAL CARRIER

Subscriber Name: _____ Subscriber ID or Social Security Number: _____

Subscriber Birth Date: _____ Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____ Group or Local Number: _____

Employer Name: _____ Employer Address:_____

Employer's Phone Number: _____ Occupation:_____

It is the policy of this office to require payment in full when services are rendered. Dental insurance is a contract between the subscriber and the insurance carrier. We are happy to process any insurance forms for you at no charge. Please leave all current insurance information and completed forms with the financial manager. For major treatment, a financial plan can be arranged with our financial manager prior to treatment. A current credit report will be acquired. A finance charge of 1.0% on the unpaid balance will be charged on all accounts.

Method of payment: Cash Payments ❒ Credit Card Payments ❒ Please Tell Me About Financing Options ❒

Patient or Guardian Signature: _____ Date: _____