

PATIENT REGISTRATION

Patient's Name: _____ Date of Birth _____

How do you wish to be addressed: _____

(Circle One) Single Married Divorced Widowed Minor

Residence Address, Street: _____

City: _____ State _____ Zip _____

Telephone: Res. _____ Bus. _____ Cell _____

E-mail Address: _____

Patient Employed By: _____

Spouse Name: _____

Spouse Employed By: _____

How did you hear about our office? _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name: _____

Employee Date of Birth: _____

Employer: _____

Name of Insurance Co.: _____

Policy #: _____

Social Security #: _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name: _____

Employee Date of Birth: _____

Employer: _____

Name of Insurance Co.: _____

Policy #: _____

Social Security #: _____

**WE ARE IN-NETWORK PROVIDERS FOR WEA AND DELTA DENTAL PREMIER INSURANCE ONLY!
ALL OTHER INSURANCES WE ARE OUT-OF-NETWORK.
PATIENTS ARE RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE.
IF YOU DO NOT HAVE INSURANCE, WE DO ASK FOR PAYMENT IN FULL ON THE DAY OF SERVICE.**

RELEASE

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, advise 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, advise and treatment to another dentist.
I understand that I am responsible for all costs of dental treatment.
I give my permission to the office to use my photographs in any presentation without recourse or compensation.
I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.
I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____