PATIENT REGISTRATION FORM

Circle One
Mr. Ms. Miss
Mrs. Dr.

Name_____ **Date of Birth**_____

How do you wish to be addressed?_____

If Patient is a minor: Parents(s) Name_____

Mailing Address

Street_____ Home #_____

City_____ State_____ Zip Code_____ Cell #_____

Home Address (If different than above)

Street_____ Email_____

City_____ State_____ Zip Code_____

Dental Insurance (Primary)

Employee Name _____ Office #_____

Employee Date of Birth_____

Employer_____

Name of Insurance Co._____

Policy # _____ Group # _____

Dental Insurance (Secondary)

Employee Name _____ Office # _____

Employee Date of Birth_____

Employer_____

Name of Insurance Co._____

Policy # _____ Group # _____

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, advice and treatment provided for the purpose of evaluation and administering claim for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible to the accuracy of the information on this page.

Patient and or Parent/Guardian Signature

X_____ Date_____