PATIENT REGISTRATION

Please Print

Date_______________ Home Phone_________________________

Cell Phone __________________________

Email____

Patient Name____Sex M☐ F☐

Street Address______________________________________City______________________Zip___________

Age_____ Birthdate____________________Single☐ Married☐ Widowed☐ Divorced☐

Driver's License Number____

Employed by____Occupation______________________________

Business Address_______________________________________ Business Phone_________________________

Spouse/Parent Name_____________________________Spouse/Parent Birthdate_________________________

Spouse/Parent Employed by____________________________ Occupation______________________________

Business Address_______________________________________ Business Phone_________________________

Social Security #_________________________ Spouse/Parent Social Security #_________________________

Who is responsible for this account_______________________ Relationship to patient____________________

Name of Dental Insurance Company___________________________________Group #___________________

Name of Secondary Dental Insurance Company_________________________Group #____________________

Physicians Name________________________________City________________Phone___________________

Previous Dentist's name__________________________City________________ Phone___________________

In case of emergency, who should be notified________________________Phone________________________

Whom may we Thank for referring you?____

Would you like to be contacted via email ? Yes____

If there were one thing you could change about your smile what would it be?

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ASSIGNMENT AND RELEASE

I understand my signature authorizes release of medical information necessary to consult with other providers concerning medical/dental conditions which may exist. I authorize the use of this signature on all my insurance submissions whether manual or electronic to release all Benefits, if any, otherwise payable to me for services rendered. **I understand I may be responsible for charges incurred for missed or broken appointments. A service charge of 7 APR will apply to accounts that are outstanding 60 days or longer. I also understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature____Date________________________