PATIENT REGISTRATION

Name: _____ Date of Birth:_____

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

Home Phone: _____Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Marital Status: _____

Occupation: _____Employer:_____

E-Mail Address_____

Parent's Name (if patient is a minor): _____

Name and Phone Number of Emergency Contact: _____

Whom may we thank for referring you to our office? _____

Name, & phone number of nearest relative not living with you:_____

Relationship to Patient:_____

FINANCIAL INFORMATION

Name of person financially responsible for this patient: _____

Address: _____ City: _____State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____ Social Security #:_____

Employer Name and Phone Number: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Carrier: _____Group or Contract No:_____

Address: _____Phone Number:_____

Insured's Name:_____ Insured's Date of Birth: _____

Insured's Social Security No:_____ Insured's Employer:_____

Secondary Insurance Carrier:_____ Group or Contact No:_____

Address: _____ Phone Number: _____

Insured's Name;_____ Insured's Date of Birth: _____

Insured's Social Security No: _____ Insured's Employer: _____

Please note that our office policy requires payment at the time services are provided.

Regardless of any anticipated insurance benefits, I understand that I am fully responsible for the payment of any balance on this account:

Signature: _____ Date: _____