

Patient Registration Form



Patient Information

First Name: _____

Last Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Okay to leave message

Cell Phone: _____ Okay to leave message

Employer: _____

Work Phone: _____ Okay to leave message

Birth Date: _____

Soc. Sec.: _____ Male or Female

Would you like email correspondences? Yes or No

If yes - Email Address: _____

Have you been to the dentist in the last year? Yes or No

If yes, approximate date: _____

Emergency Contact Name: _____

Phone Number _____ Relationship: _____

Responsible Party Same as above

First Name: _____

Last name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

Birth Date: _____

Soc. Sec.: _____

Your Relationship to Responsible Party: _____

Primary Insurance Information

First Name of Policyholder: _____

Last Name of Policyholder: _____

Policyholder Soc. Sec.: _____

Policyholder Birth Date: _____

Policyholder Employer: _____

Insurance Co: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

Your Relationship to Policyholder _____

Secondary Insurance Information

First Name of Policyholder: _____

Last Name of Policyholder: _____

Policyholder Soc. Sec.: _____

Policyholder Birth Date: _____

Policyholder Employer: _____

Insurance Co: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I hereby authorize the administration of such medications and performance of such dental procedures that may be necessary for proper dental care.

Patient's Signature (parent or guardian if a minor) _____ Date: _____