PATIENT REGISTRATION FORM

(This information is necessary for our files and your health and will be considered **CONFIDENTIAL**)

Last Name _____ First _____ Mi _____ M F

I prefer to be called: _____ Birthday: ___/___/___ Age: _____ Single Married Divorced

Social Security #: _____ Drivers License#: _____ Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Ext.: _____ Cell #: _____

Whom may we Thank for referring you? _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

If patient is a student-Name of school: _____

Neighbor or Relative not living with you

His/Her Name: _____ Relation: _____ Home Phone #.: ( ) _____

Address: _____ Work Phone #.: ( ) _____
Street City State Zip

Person Responsible for Account if other than Yourself

Name: _____ Relation: _____ Home Phone #.: ( ) _____

Employer: _____ Work Phone #: _____ Ext.: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

Spouse/Parent Information

Name: _____ Birthday: ___/___/___ Social Security #.: _____

Employer: _____ Work Phone #: ( ) _____ Ext.: _____ Driver's License #: _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insureds' Name: _____ SS#: _____ Insureds' Birthday.: ___/___/___ Relation: _____

Insureds' Employer: _____ Employer Address: _____
Street City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone #: ( ) _____ Group#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ SS#: _____ Insured's Birthday.: ___/___/___ Relation: _____

Insured's Employer: _____ Employer Address: _____
Street City State Zip

PATIENT RESPONSIBLE FOR FEES: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid within 30 days of the date on which examinations are provided. I hereby authorize that the payment from any insurance company due me be paid directly to the working practice In the event of default in payment patient or party responsible for fees agree to pay any and all costs of suit, collection and attorney's fees.

Insurance is filed as a courtesy, A minimum notice of cancellation 24 hours prior to your appointment is required or a cancellation fee of $25 may occur.

By signing below I consent to the dental treatment provided by this practice. The information provided is accurate to the best of my knowledge.

☐ Check the box acknowledging that you have received the copy of HIPPA Privacy Practices.

Signature - Patient or Responsible Party _____ Date _____