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

Your Relationship to Responsible Party:_____

First Name:_____ Last name:_____ M.I._____

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

Home Phone:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Birth Date:_____ Soc. Sec.:_____

Primary Insurance Information

Your Relationship to Policyholder_____

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: _____

Secondary Insurance Information

Your Relationship to Policyholder _____

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: _____