DELANEY FAMILY DENTAL
REGISTRATION FORM

Please Print and fill this form out completely.

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:			D.O.B. / /	❑ female ❑ male	Marital status (circle one) Single / Mar / Div /Sep / Wid/child
Social Security no.:	Drivers License no.:		Home phone no.: ( )		Cell phone no.: ( )
Street address:	City:		State:		ZIP Code:
Email address:	Employer:				Employer phone no.: ( )
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION					
(**Please give your insurance card and a photo ID to the receptionist.**)					
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Name of Dental Insurance:			Phone number:		
Is this patient covered by insurance?	❑ Yes	❑ No			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

What is you long term goal for your smile? _____

If you could have anything done to improve your smile what would it be? _____

The above information is true. I authorize my insurance benefits be paid directly to the Dr. Delaney. ***I understand that I am financially responsible for any balance. Any balances past due in excess of thirty days are subject to further legal action.*** *I am also aware of the $75.00 no show or late cancelation fee. I also authorize Delaney Family Dental or insurance company to release any information required to process my claim. By signing this form I am also willingly giving Delaney Family Dental the consent to treatment as they deem necessary.*

Patient/Guardian signature *Date*