

# 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. / /	<input type="checkbox"/> female <input type="checkbox"/> 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):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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? _____			
<p><i>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.</i></p>			

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date