Patient Information

Patient Name: _____ Date: _____
Last First Middle
(if patient is full time student, fill in school name): _____
Address: _____
Street City State Zip
Home Phone: _____ Cell Phone: _____ Work: _____
May we contact you on your cell or at work? Y N Birth date: _____
If patient is a minor, give parents or guardian's name: _____
Name of nearest relative no living with you: _____
Complete Address: _____ Phone: _____

Responsible Party Information

Name: _____
Last First Middle Marital Status
Residence: _____
Street City State Zip
Mailing Address: _____
Street City State Zip
How long at this address? _____ Home Phone: _____ Work Phone: _____
Previous address (if less than 3 years) _____
Street City State Zip
Social Security #: _____ Relationship to Patient: _____
Date of Birth: _____ Employer: _____ Occupation: _____
Employer Address: _____
Street City State Zip
Spouse's Name: _____
Street City State Zip
Date of Birth: _____ Employer: _____ Occupation: _____
Employer Address: _____
Street City State Zip
Social Security #: _____ Work phone: _____

Insurance Information

Insured's Name: _____ Relationship to Patient: _____
Insurance Co: _____Group #: _____
Insurance Co. Address: _____ Phone #: _____
Is policy connected with your union? Yes __ No -_ Name of Union: _____Local #: ____
Do you have dual coverage? Yes __ No __ If yes: Please complete the following secondary insurance information.
Insured's Name: _____ Insured's Social Security #: _____
Insurance Co: _____ Group #: _____Local #: _____
Insurance Co. Address: _____ Phone #: _____
Insured's Employer: _____ Phone #: _____
Address: _____

1. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection charged. Irregardless of insurance coverage.
2. I understand that where appropriate, credit bureau reports may be obtained.
3. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Signature: _____ Date: _____

PATIENT REGISTRATION