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