Welcome To Our Office

Last First Middle

Patient Name _____ Birth Date _____

Male Female Married Single Divorced Widow Widower

Street Address _____ Home Phone No. _____

City _____ Zip Code _____ Social Security No. _____

Email Address _____

Employer Name _____ Drivers License No. _____

Employer Address _____ Work Phone No. _____

Referred by _____ Cell Phone No. _____

Do you have Dental Insurance Yes ☐ No ☐ Occupation _____ Employer City _____

If so, Name of Insurance Co. _____ Group No. _____

Subscriber Name _____ Spouse ☐ Father ☐ Mother ☐ Other _____

When was your last visit to the dentist? _____

Does your spouse have Dental Insurance? Yes ☐ No ☐

If so, Name of Insurance Co. _____

Employer's Name _____ Address _____

Phone # _____ Social Security No. _____

In case of emergency notify _____

ASSIGNMENT AND AUTHORIZATION

I hereby assign to _____, payment of Dental Benefits due me under the policy and authorize release of information concerning my illness or injuries to insurance carriers.

A photocopy of this authorization shall be as valid as the original.

_____ _____

Date Signature of Insured

Payment is due when services are rendered, unless prior arrangements have been made with the office manager. All delinquent accounts over 90 days are service charged at the legal rate.

I hereby authorize and give consent to have all services and treatment, including oral surgery, deemed necessary or advisable.

Signature _____ Date _____

REGISTRATION