Welcome

Account #

Patient' Name _____
Last First Initial

Date _____ Date of Birth _____ ☐ Male ☐ Female

If Child: Parent's Name _____

How do you wish to be addressed _____

Single ☐ Married ☐ Separated ☐ Widowed ☐ Minor ☐

Residence-Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____

Fax _____ Cell Phone _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referal _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you __

_____

Dental Insurance 1st Coverage

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or Policy# _____
Social Security No. _____
Union local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____
_____
Telephone _____
Program or Policy # _____
Social Security Number _____
Union Local or Group _____

RELEASE:
I authorize the doctor to perform diagnostic procedures; including x-rays, photos, study models, or anything deemed appropriate to make a thorough diagnosis of my dental and or medical needs. I authorize the doctor to perform all forms of therapy, including medications that are required for successful treatment.

I understand the use of anesthetic agents embodies a certain risk.

I authorize the release of any information to another dentist pertaining to my treatment for the purpose of referral.

I authorize the release of any information to my insurance company that my insurance company requires for the purpose of benefit payments and determination.
I understand that my dental insurance is a contract between my insurance carrier and myself. It is not a contract between my insurance carrier and the dentist. I am FULLY responsible for all dental fees incurred that are NOT covered by my insurance. These fees are due at the time services are rendered, unless prior arrangements have been made. I agree to the finance charges added to any account with a past due balance.

I attest to the accuracy of the information on this page.

Patient Signature (Guardian) _____ Date _____

Dentist Signature _____

New Patient Registration