CAROLINA DENTAL ASSOCIATES

Patient Registration/Update

Today's Date _____ Patient's Name _____
MM/DD/YYYY Last First Middle Initials

Date of Birth _____/_____/_____ __ Married __ Single __ Male __ Female __ Minor (under 18 yrs old)
MM/DD/YYYY
__ Partnered

If Child: Parent's Name _____ Is child a Full-time college student? ___ Yes ___ No

Whom may we thank for this referral? _____ **How did you hear about us?** _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

E-Mail _____ (We only use it for appointment reminders and correspondences)

Person Responsible for this account _____ Drivers License No. _____

Patient/Parent Employed By _____ Spouse Employed By _____

Patient/Parent Social Security No. _____

Other Family Members in this Practice _____

Someone to notify in case of emergency not living with you _____ Phone (_____) _____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured _____ Social Security # _____

Relationship to Patient ____ Self ____ Father ____ Mother ____ Spouse ___ Partner

Insured Date of Birth _____ Insured Employer Name _____

Employer Street Address _____ Work Phone (_____) _____

Name of Insurance Company _____ Group/Policy # _____

Subscriber ID# _____ Insurance Co. Phone # _____

Insurance Company Street address _____ City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insured _____ Social Security # _____

Relationship to Patient ____ Self ____ Father ____ Mother ____ Spouse ___ Partner

Insured Date of Birth _____ Insured Employer Name _____

Employer Street Address _____ Work Phone (_____) _____

Name of Insurance Company _____ Group/Policy # _____

Subscriber ID# _____ Insurance Co. Phone # _____

Insurance Company Street address _____ City _____ State _____ Zip _____

Consent:

I consent to the diagnostic, photographic and therapeutic procedures and treatment by the dentist necessary for proper dental care. I grant the right to Carolina Dental Associates to release my dental/medical histories and other information about my dental treatment to third party payors and/or other healthcare professionals.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____