PATIENT REGISTRATION

LAST NAME:_____FIRST NAME:_____
MIDDLE NAME:_____PREFERRED NAME:_____
SS NUMBER:_____DATE OF BIRTH:_____SEX:_____MARITAL STATUS:_____

HOME ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE:_____WORK PHONE:_____CELL PHONE:_____
EMAIL ADDRESS:_____

WHOM MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE?_____

YOUR OCCUPATION:_____
EMPLOYED BY:_____
EMPLOYER'S ADDRESS:_____
CITY, STATE, ZIP:_____

SPOUSE'S NAME:_____
SPOUSE'S OCCUPATION:_____
EMPLOYED BY:_____
BUSINESS PHONE:_____

PRIMARY DENTAL INSURANCE INFORMATION
INSURED PERSON'S NAME &
ADDRESS:_____
_____
S.S. NO._____DATE OF BIRTH:_____
EMPLOYER'S NAME & ADDRESS:_____
INSURANCE CO. NAME &
ADDRESS:_____
_____
GROUP NO._____INSURANCE PHONE NO._____

IN CASE OF EMERGENCY, PLEASE CONTACT:_____
ADDRESS:_____
WORK PHONE:_____HOME PHONE:_____

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic procedures deemed appropriate to make a thorough diagnosis of my dental needs. I understand that responsibility for payment of dental services provided in this office for myself and my dependents, is mine and due at the time of services. I further understand that there are times that insurance companies do not pay everything that they say the will initially, therefore I understand and agree that I am responsible for all amount not paid by the insurance company. I understand that if payment is not received from my insurance company within 60 days, I will be responsible for payment in full at the time. I understand and agree that accounts over 60 days are subject to interest fees and that I am responsible for any reasonable attorney's fees and court costs involved in the collection of any unpaid balance of this account.

PATIENT'S SIGNATURE:_____DATE:_____
(OR RESPONSIBLE PARTY'S SIGNATURE)