DR. D'S FAMILY DENTISTRY
REGISTRATION

PATIENT'S
NAME _____ Date _____Date of Birth_____
Last First Initial

IF CHILD:
PARENT'S NAME_____
Last First Initial
Nickname (if applicable)_____

Single Ω Married Ω Separated Ω Divorced Ω Widowed Ω Minor Ω

RESIDENCE – STREET _____

_____

CITY_____STATE_____ZIP_____

Email address: _____

BUSINESS ADDRESS_____

PHONE:HM _____WK_____ CELL_____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____HOW LONG_____

SPOUSE/PARENT NAME_____

SPOUSE EMPLOYED BY _____

PRESENT POSITION_____HOW LONG_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT_____

METHOD OF PAYMENT: Insurance Ω Credit Card Ω Cash Ω

PURPOSE OF VISIT _____

OTHER FAMILY MEMBERS IN THIS PRACTICE_____

_____

WHOM MAY WE THANK FOR THIS REFERRAL_____

WHEN WAS YOUR LAST DENTAL APPOINTMENT_____

PATIENT/PARENT SOCIAL SECURITY #_____

SPOUSE/PARENT SOCIAL SECURITY #_____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY

NOT LIVING WITH YOU _____

PHONE:

DENTAL INSURANCE 1ST Coverage

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

NAME OF INSURANCE _____

ID#_____

ADDRESS_____

EMPLOYER _____#YRS_____

_____

TELEPHONE _____

POLICY #_____

UNION LOCAL OR GROUP #_____

SOCIAL SECURITY #_____

DENTAL INSURANCE 2nd Coverage

EMPLOYEE NAME_____

EMPLOYEE DATE OF BIRTH_____

EMPLOYER _____#YRS_____

NAME OF INSURANCE _____

ADDRESS_____

_____

TELEPHONE _____

POLICY #_____

UNION LOCAL OR GROUP #_____

SOCIAL SECURITY #_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments 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, in whole or in part by my dental care payer.
I understand that should my account be turned over for collection, the court costs, attorney fees and all other collection fees are my responsibility.
I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE_____DATE_____