PATIENT INFORMATION

PATIENT

Name_____

Address_____ Apt #_____

City _____ Zip_____

How long at this address? _____

Phone ( )_____ Cell ( )_____

E-mail _____

Social Security # _____ Age _____

Birthdate _____ Married ☐ Single ☐ Divorced ☐

Emergency Contact _____

Phone ( )_____ Cell ( )_____

How did you hear about us? _____

RESPONSIBLE PARTY

Name_____

Adress_____ Apt # _____

City_____Zip_____

How long at this address? _____

Phone ( )_____Cell ( )_____

Email_____

Social Security # _____

Age_____ Birthdate_____

Relationship to patient _____

EMPLOYMENT

Occupation_____

Employer _____ How long? _____

Business Address _____

City _____ Zip _____

Business Phone ( )_____ Ext. _____

INSURANCE INFORMATION

Primary ID # _____

Plan Name_____ Phone ( )_____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

Secondary ID # _____

Plan Name _____ Phone ( )_____

Insured's Name _____

Insured's Soc. Sec. # _____ Birthdate _____

RELEASE: I certify that the information provided on this page is accurate and will be relied upon for granting credit and providing dental services. I hereby authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit agencies. 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 understand that I am responsible for all costs of dental treatment. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.

_____

SIGNATURE DATE

We Appreciate Your Referrals!

REGISTRATION