CONFIDENTIAL

Patient Registration Information

Date _____

Name _____ **Pref. name** _____ **Social Security #** _____
First MI Last

Welcome to our Practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

Home address _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Are you: ____ Minor ____ Single ____ Married

Spouse or parent's name _____ Relationship _____ Work Phone _____

If you are a student, name of school/college _____ City _____ State _____

Person to contract in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account _____ Relationship _____

Address (if different from yours) _____ Home Phone _____

City, State, Zip _____ Social Security # _____

Employer _____ Work Phone _____

Is this person currently a patient in our office? _____ Yes _____ No

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Dental Insurance Information

Name of Insured _____ Relationship to Patient _____ Birthdate _____

Social Security # _____ Employer _____ Work Phone _____

Address of Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____ Ins. Co. Address _____

Secondary Dental Insurance

Name of Insured _____ Relationship to Patient _____ Birthdate _____

Social Security # _____ Employer _____ Work Phone _____

Address of Employer _____ City, State, Zip _____

Insurance Company _____ Group # _____ Ins. Co. Address _____

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care, to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment of all services rendered on my behalf or on behalf of my dependents.

Late Charges

If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the unpaid balance owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

X _____ **Date** _____

Signature of patient or parent if minor