PATIENT REGISTRATION

Please fill out the following information . All fields are required in order to complete the registration process.

PATIENT INFORMATION				
Legal Name: (*first*)	(*middle*)	(*last*)		Date of Birth: / /
Address: (*street*)	(*city*)	(*state*)	(*zip*)	
Home #	Cell #	Work #		
Gender: ☐ Male ☐ Female	Marital Status: : ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			
SS#: _ _	Employer:			
Occupation:	Emergency Contact Name:			
Contact's Telephone: (*home #*)	(*cell #*)	(*work #*)		
Whom may we thank for referring you?				

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
Legal Name: (*first*)	(*middle*)	(*last*)	Date of Birth: / /
Address: (*street*)	(*city*)	(*state*)	(*zip*)
Home #	Cell #	Work #	
Email Address	SS#: _ _	Driver's License Number:	
Employer:	Is this person an existing patient or account holder? ☐ Yes ☐ No		
Relationship To Above Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (please specify)			

DENTAL INSURANCE INFORMATION			
Insurance Company:			
Address: (*street*)	(*city*)	(*state*)	(*zip*)
Subscriber's Name *(as shown on policy or ins. card):*	Plan Name *(as shown on policy or ins. card):*		
Group or Plan ID#	Subscriber's SS#: _ _	Subscriber or Employee ID#	
Subscriber's Date of Birth: / /	Name of Employer		
Subscriber's Relationship To Above Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other (please specify)			

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for my dental care. I consent to the dentist to use and disclose my records (or my child's records) to provide treatment, obtain payment and for those activities and health care functions that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke it in writing:

_____

I authorize payment directly to the dentist or the dental group of insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services, and that I am financially responsible for payment in full of my account.

Patient's Or Guardian's Signature _____Date_____