PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES ON PAGES 1 AND 2

PATIENT INFORMATION

TODAY'S DATE:

PATIENT FULL NAME (LAST, FIRST, MIDDLE): | AGE | DATE OF BIRTH / /

PATIENT PHONE NO. HOME ( ) | WORK ( ) | MOBILE ( ) | FAX ( )

SOCIAL SECURITY NO.: - - | SEX: M F | MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED SEPARATED DIVORCED WIDOWED

PHYSICAL ADDRESS (NOT P.O. BOXES): STREET | CITY | STATE | ZIP

MAILING ADDRESS (IF DIFFERENT THAN PHYSICAL ADDRESS):

E-MAIL ADDRESS: | LANDLORD NAME: | LANDLORD PHONE NO. ( )

EMPLOYER NAME: | OCCUPATION: | EMPLOYER PHONE NO. ( )

EMPLOYER ADDRESS: STREET | CITY | STATE | ZIP

SPOUSE'S FULL NAME (LAST - FIRST - MIDDLE):

SPOUSE'S PHONE NO. HOME ( ) | WORK ( ) | CELL ( ) | FAX ( )

EMERGENCY CONTACT(NAME): | RELATIONSHIP | PHONE NO. ( )

WHO REFERRED YOU HERE? (NAME) | (CIRCLE ONE) FRIEND / RELATIVE PHONE BOOK ADVERTISEMENT WEB

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (NAME: LAST - FIRST - MIDDLE): | DATE OF BIRTH / /

PHYSICAL ADDRESS (NOT P.O. BOXES): STREET | CITY | STATE | ZIP

PHONE NO. HOME ( ) | WORK ( ) | CELL ( ) | FAX ( )

SOCIAL SECURITY NO.: - - | DRIVER'S LICENSE NO.:

EMPLOYER NAME: | OCCUPATION: | EMPLOYER PHONE NO. ( )

EMPLOYER ADDRESS: STREET | CITY | STATE | ZIP

HOW WILL YOU BE PAYING FOR TODAY'S SERVICES: (CIRCLE ONE)

CASH CHECK CREDIT/DEBIT CARD MEDICAL ASSISTANCE DENTAL INSURANCE COMMERCIAL FINANCING

PATIENT REGISTRATION

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY			INS. PHONE NO.: ( )
INSURANCE COMPANY ADDRESS (STREET - CITY - STATE - ZIP):			POLICY NO.:
NAME OF INSURED:	RELATIONSHIP (CIRCLE ONE): SELF SPOUSE DEPENDENT	ID NO.:	GROUP NO.:
SECONDARY DENTAL INSURANCE COMPANY			INS. PHONE NO.: ( )
INSURANCE COMPANY ADDRESS (STREET - CITY - STATE - ZIP):			POLICY NO.:
NAME OF INSURED:	RELATIONSHIP (CIRCLE ONE): SELF SPOUSE DEPENDENT	ID NO.:	GROUP NO.:

ASSIGNMENT OF INSURANCE BENEFIT PAYMENTS (VALID UNTILCANCELLED BY WRITTEN NOTICE)

SIGNATURE OF PRIMARY INSURANCE HOLDER _____DATE_____

SIGNATURE OF SECONARY INSURANCE HOLDER _____ DATE_____

CONSENTS AND SIGNATURES

TREATMENT

I authorize the use of all modalities, therapies, interventions, methodology, medications and pharmaceuticals, assistance, instrumentation, and procedures deemed necessary for the delivery of dental services and treatment to the patient registered on this form. I acknowledge that all instructions and professional advice must be followed for optimal results. Upon request, the patient is entitled to an explanation of all treatment, including the benefits, risks, alternatives available, expected outcomes, as well as, the risks of non treatment.

PATIENT SIGNATURE OR LEGAL DESIGNEE _____DATE_____

FINANCIAL POLICY

I agree to pay all fees for the patient registered on this form at the time services are delivered or rendered, including all service not covered by dental insurance or 3rd party payers, deductibles, and co-payments; I agree that payment will not be delayed because of divorce, separation, or pending dental claim status. I realize I am responsible for understanding the coverages and limitations of any benefit plans involved. I will notify this office of changes in my name, billing address, phone numbers employment, dental plan name, account ID numbers, claim submission address, or deductibles. The complete financial policy of this office, terms and conditions, is available to me upon request.

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT _____DATE_____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT _____DATE_____

CONSENT TO TRANFER BALANCES TO CREDIT CARD

SIGNATURE OF CARD HOLDER_____EXPIRATION DATE_____