

DENTAL REGISTRATION AND HISTORY



(PLEASE PRINT)

Date _____ Email _____ Home Phone _____
Cell Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Spouse or Parents name _____ Employer _____ Work # _____
If Patient is a student, name or school/college _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Driver's License # _____ Birthdate _____ Bank _____
Employer _____ Work Phone _____
Currently a Patient in our Office? Yes No S.S. # _____

INSURANCE INFORMATION

Name of Insured _____ Last Name First Name Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone _____
Person Responsible Employed by _____ Occupation _____ Date Employed _____
Business Address _____ Business Phone _____
Insurance Company _____ Address _____
Contract # _____ Group # _____ Subscriber # _____
How much is your Deductible? _____ How much have you used? _____ Max. Annual Benefit _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

Date _____

Signature of Insured/Guardian _____