PATIENT REGISTRATION

DATE:_____

NAME:_____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS:_____
STREET APT# CITY STATE ZIP

BIRTHDATE:_____ TELEPHONE:_____
MO DAY YEAR HOME CELL OFFICE

FULL TIME STUDENT ☐ SCHOOL ATTENDING:_____
NAME ADDRESS

SOCIAL SECURITY NO:_____ Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME:_____

State Driver's License Number:_____

ACCOUNT & INSURANCE REGISTRATION

(FILL IN BOTH BLOCKS)

	SELF/(OR FATHER IF MINOR CHILD)	SPOUSE (OR MOTHER IF MINOR CHILD)
NAME:	LAST FIRST M	LAST FIRST M
ADDRESS:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
BIRTHDATE/SS#	MO DAY YEAR SS#	MO DAY YEAR SS#
EMPLOYER:	EMPLOYER	EMPLOYER
DENTAL INSURANCE CO:	DENTAL INSURANCE	DENTAL INSURANCE
GROUP#:	GROUP#	GROUP#

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY / HOUSEHOLD IN CASE OF EMERGENCY

NAME:_____ TEL#_____
LAST FIRST M

ADDRESS:_____
STREET CITY STATE ZIP

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

PLEASE NOTE: Appointments are reserved in advance that you may have sufficient time to check your schedule for any personal conflicts. Changes in your appointment affect many patients. Please do not make appointment changes, unless an emergency arises. **A minimum of $75.00 may be charged for broken appointments. Please don't let this happen.**

X_____ Date:_____

☐ Adult Patient ☐ Husband (or Father) ☐ Wife (or Mother) ☐ Guardian

PATIENT INFORMATION