ADULT PATIENT REGISTRATION / INSURANCE INFORMATION

So that we may provide you with the best possible care, please complete this entire form. PLEASE PRINT

Patient Name ____ Date ______________________
Address ____ City _______________________ State ______ Zip ________
Home Phone ______________________ Work Phone ________________________ Cell Phone ______________________
Social Security # ____________________________ E-mail Address ____
Preferred method of contact: Phone Call Text Message E-mail
Sex: Male Female Age_____ Birthday ____/____/_______ Single Married Separated Divorced Widowed

Employed By ____________________________________ Occupation ____
Business Address ____ City ___________________________ State ______ Zip __________

Partner Name ________________________________ Birthday ____/____/ _______ Social Security # _____________________
Employed By____________________________________ Occupation ____
Business Address ____ City ____________________________ State _____ Zip ___________

Who is responsible for this account? _____________________________________ Relationship to patient _________________________
Billing Address ____

PRIMARY INSURANCE

Insured's Name ____ Social Security # _________________________
Insurance Company ____ Ins. Co. Phone Number ____________________
Address ____
Group Number _______________________________ ID Number ___________________________ Birthdate ___/___/______
Insured's Employer ____

SECONDARY INSURANCE

Insured's Name ____ Social Security # _________________________
Insurance Company ____ Ins. Co. Phone Number ____________________
Address ____
Group Number _______________________________ ID Number ___________________________ Birthdate ___/___/______
Insured's Employer ____

In case of an emergency, who should be notified? ____ Tel. _______________________
Who is your previous dentist? ____ Tel. _______________________

Pharmacy Name, Address & Phone ____

Whom may we thank for referring you? ____

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing, and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners. I authorize my insurance company to pay directly to the dental office the 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 payment of all services rendered on my behalf or my dependents. If you must change or cancel an appointment we require that you communicate directly with our staff and give two full working days' notice, or a cancellation fee will be charged.

____ ___________________________________
Signature of patient or parent of minor Date