Welcome

Date____________________

Patient's Name _______________________________ **Date of Birth** __________________**Age** _________

If child: Parent's Name __________________________
How do you wish to be addressed __________________
Single ○ Married ○ Divorced ○ Widowed ○ Minor ○
Address _______________________________________
City _______________State_______Zip_____________
Telephone: Home#_____________Work#_____________
Cell#________________
eMail____
Who is responsible for this account _________________
Drivers License No. _____________________________
Method of Payment: Insurance ○ Cash ○ Credit Card ○
Other Family Members in this Practice _______________
____
Whom may we thank for this referral_________________
Patient/ Parent Social Security No.__________________
Spouse/ Parent Social Security No. __________________

Dental Insurance 1st Coverage

Employee Name_____________Date of Birth___________
Relationship to patient ___________________________
Employer Name ___________________________________
Name of Insurance Co. ____________________________
Address ____
____
Telephone _______________________________________
Subrcriber # _____________________________________
Group# ____

Dental Insurance 2nd Coverage

Employee Name_____________Date of Birth__________
Relationship to patient ___________________________
Employer Name ___________________________________
Name of Insurance Co. ____________________________
Address ____
____
Telephone _______________________________________
Subsrcriber # _____________________________________
Group# ____

Consent:

I consent to the diagnostic procedures and treatment by the Dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain Payment, and for those activities and health care oper-Ations 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 dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits May pay less than the actual bill for services, and that I am Financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services Not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Please Sign Below:

Patient's or Guardian's Signature:

____ ____

REGISTRATION