PATIENT INFORMATION

DATE _____

NAME _____ ☐ MALE ☐ FEMALE ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED
LAST FIRST M

ADDRESS _____
STREET APT# CITY STATE ZIP

BIRTH DATE _____ TELEPHONE _____
MONTH DAY YEAR CELL# HOME# WORK#

PLACE OF EMPLOYMENT _____ PATIENT'S SS# _____

PRESENT POSITION _____ HOW LONG? _____

EMAIL ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

IF MINOR, PARENT OR GUARDIAN _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO NAME _____

Whom may we thank for referring you to our office? _____

Are you available on short notice? ☐ YES ☐ NO Phone# where you can be reached _____

INSURANCE INFORMATION

INSURED (1ST COVERAGE)				INSURED 2ND COVERAGE)			
LAST	FIRST		MI	LAST	FIRST		MI
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME PHONE#	WORK PHONE#			HOME PHONE#	WORK PHONE#		
BIRTH DATE (MO/DAY/YEAR)			SS#	BIRTH DATE (MO/DAY/YEAR)			SS#
EMPLOYER				EMPLOYER			
DENTAL INSURANCE CO.	SUBSCRIBER#		GROUP#	DENTAL INSURANCE CO.	SUBSCRIBER#		GROUP#
ADDRESS	CITY	STATE		ADDRESS	CITY	STATE	

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family/Household

Name _____

Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Please Check One

☐ Patient ☐ Father ☐ Husband

☐ Guardian ☐ Mother ☐ Wife

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 medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____
SIGNATURE OF RESPONSIBLE PARTY DATE

REGISTRATION