Patient Registration

(Please Print)

Chart #:_____ **Date:**_____

Patient Name_____Soc.Sec. #_____
Last Name First Name Initial

Address_____

City _____State_____Zip_____

Home (____)_____ Cell Phone/Pager (____)_____
(Area code) (Area code)

Sex, M____F____ Age____ Birthdate_____ Single_____ Married_____ Separated_____ Divorced_____Widow/er_____

Employer _____Wk# (___)_____Ext._____
(Area Code)

Spouse_____ Contact Phone _____General Dentist_____

In case of emergency, Who should be notified?_____Phone(____)_____
(Area code)

Relationship to patient_____

If different from patient, please fill out information below:

Person Responsible for account_____ Soc.Sec.#_____
Relationship to Patient_____
Contact Number Home (____)_____ Work(____)_____Ext._____
(Area code) (Area code)

Primary Insurance

Complete this section if covered by Dental Insurance (this information applies to the party (the subscriber) who carries the insurance policy

Name of Insured_____Date of Birth_____ Soc.Sec#_____
Employer_____Work #(___)_____Ext._____
(Area code)

Insurance Co._____
Address_____
Insurance Co. Phone #(____)_____Group #_____
(Area code)

I herby authorize the Dr. and staff to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, yet understand whether or not paid by my dental insurance, I am responsible for all charges for treatment.

_____ _____ _____
Signature of patient / responsible party (relationship) Date