PATIENT NUMBER

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(800) 243-4675

Age________ Date________

Patient's Name________ Last First Initial Date of Birth________ ❑ Male ❑ Female

If Child: Parent's Name________

How do you wish to be addressed________

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street________

City________ State____ Zip________

Business Address________

Telephone: Res.________ Bus.________

Fax________ Cell Phone #________

eMail________

Patient/Parent Employed By________

Present Position________

How Long Held________

Spouse/Parent Name________

Spouse Employed By________

Present Position________

How Long Held________

Who is Responsible for this account________

Drivers License No.________

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call________

Other Family Members in this Practice________

____

Whom may we thank for this referral________

Patient/parent Social Security No.________

Spouse/Parent Social Security No.________

Someone to notify in case of emergency not living with you________

____

DENTAL INSURANCE 1ST COVERAGE

Employee Name________ Date of Birth________

Relationship to patient________

Employer Name________ Yrs.____

Name of Insurance Co.________

Address________

____

Telephone________

Program or policy #________

Social Security No.________

Union Local or Group________

DENTAL INSURANCE 2ND COVERAGE

Employee Name________ Date of Birth________

Relationship to patient________

Employer Name________ Yrs.____

Name of Insurance Co.________

Address________

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Telephone________

Program or policy #________

Social Security No.________

Union Local or 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 operations 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.

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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.

PATIENT'S OR GUARDIAN'S SIGNATURE

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DATE________

Form No. T110R

REGISTRATION