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 ______

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.

______

______

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

______

DATE ______

Form No. T110R

REGISTRATION