CONFIDENTIAL PATIENT REGISTRATION

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.**

Patient Name:_____
Last Name **First Name** **Middle Initial**

Preferred Name:_____

Check one: ☐ **Married** ☐ **Single** ☐ **Widowed**

Address:_____
Street City State Zip code

Date of Birth:___/___/_____ CHECK : ☐ **Male** ☐ **Female** **SSN:** _____
MM DD YYYY

Preferred method of contact :

Phone: _____☐ **Home** ☐**Work** ☐**Cell Email:**_____

Emergency Contact Name: _____ **Phone :** _____

How did you hear about us? Or Whom May We Thank For Referring You?

_____

RESPONSIBILE PARTY/BILLING INFORMATION

Person Responsible for Account (if different from above):_____ **Relationship to Patient:** ☐ Spouse ☐ Parent ☐ Other

SSN: ___–___–____ **Date of Birth:** ____/___/____
MM DD YYYY

Preferred method of Contact: Phone _____ **EMAIL:**_____

Address if different from patients: _____
Street **City** **State** **Zip code**

DENTAL INSURANCE INFORMATION

Do you have secondary dental insurance? □ **Yes** □ **No**

Please enter **PRIMARY** insurance information below: **Relationship to Policy holder :** ☐ Spouse ☐ Parent ☐ Other

Name of Primary Policyholder: _____ **Policyholder DOB:** _____ ☐ Male ☐ Female

Employer: _____ **Insurance Company:** _____

Insurance Company Phone #: _____**Subscriber ID#**_____

I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

Payment Method – Informed Consent

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

We gladly welcome any questions regarding fees and discussing your financial options prior to treatment.

Note: **All balances are due at time of service. We accept Cash, Check, Visa, and MasterCard**

I authorize my insurance carrier to issue dental/medical benefits directly to this office and the release of any information necessary to process the insurance claim

Signature: _____ **Date**: _____

Please Complete Front & Back Thank You.