GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: ______________________________

Date of Birth: ______________________________

Marital Status: Single Married Separated Divorced Widowed

Sex: Male Female

Social Security Number: ______________________________

Email Address: ______________________________

Home Phone Number: ______________________________

Cell Phone Number: ______________________________

Home Address:

Address: ______________________________

City, State and ZIP: ______________________________

Billing Address:

Address: ______________________________

City, State and ZIP: ______________________________

Work Information

Employer: ______________________________

Occupation: ______________________________

Work Phone Number: ______________________________

Method of Contact: Phone Email Text Message Any of the previous ones

Emergency Contact:

Full Name: ______________________________

Phone Number: ______________________________

Relation: ______________________________

How did you hear about our office?

Who may we thank for referring you? ______________________________

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: ______________________________

Social Security: ______________________________

Relation to Patient: ______________________________

Patient's Student Status

Student Status: ______________________________

College: ______________________________

College Address: ______________________________

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: ______________________________

Date of Birth: ______________________________

Social Security: ______________________________

Employer: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: ______________________________

Company Phone Number: ______________________________

Company City, State, ZIP: ______________________________

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: ______________________________

Date of Birth: ______________________________

Social Security: ______________________________

Employer: ______________________________

Policy Number: ______________________________

Group Number: ______________________________

Coverage Type: Individual Family Prepaid / Capitation

Insurance Company: ______________________________

Company Phone Number: ______________________________

Company City, State, ZIP: ______________________________

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: ______________________________