

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

RESIDENCE - STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

TELEPHONE: RES. \_\_\_\_\_ BUS. \_\_\_\_\_

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 \_\_\_\_\_

METHOD OF PAYMENT: Insurance  Credit Card  Cash

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 \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

**DENTAL INSURANCE 2ND COVERAGE**

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ # YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

PROGRAM OR POLICY # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

**RELEASE:**

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.
- I understand that I am responsible for all costs of dental treatment.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST.

PATIENT NUMBER

MED. ALERT

**REGISTRATION**

102-1-94