REGISTRATION INFORMATION

Personal Information:

Your name:

How do you wish to be addressed?

Street Address:
City/State: **Zip:**

Home Phone:

Work Phone:

Cell Phone:

Email Address:

Can we text or email you? ☐ **YES** ☐ **NO**

☐ **Single** ☐ **Married or domestic partner**

Date of Birth:

Your SSN:

How did you hear about us?

Emergency Information:

Whom may we notify in case of an emergency?

Name:

Home phone:

Work Phone:

Cell Phone:

Dental Insurance 1st Coverage:

Insured's name:

Date of birth:

SSN:

Employer:

Group # or Policy #

Name of Ins. Co.:

Ins. Co. phone #

Dental Insurance 2nd Coverage:

Insured's name:

Date of birth:

SSN:

Employer:

Group # or Policy #

Name of Ins. Co.:

Ins. Co. phone #

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that it is the policy of this office to discuss risks, benefits, alternatives and costs of treatment with me in advance. I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my health care, advice and treatment to another dentist or my personal physician. I herby authorize payment of insurance benefits otherwise payable to me directly to the dentist. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts, including any portion not paid by my dental care payor. I attest to the accuracy of the information provided on this form.

_____ _____

Date Signature of patient, parent, or guardian