

# REGISTRATION

## Patient Information

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female   
How do you wish to be addressed \_\_\_\_\_ Single  Married  Separated  Widowed   
Minor   
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_  
Someone to notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
Other family members in this practice \_\_\_\_\_

## Account Information

Responsible Party's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female   
SSN \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Primary Dental Insurance

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Relationship to the patient: Self  Spouse  Parent   
Name of Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/Group # \_\_\_\_\_ Insured's ID \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

## Secondary Dental Insurance

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Relationship to the patient: Self  Spouse  Parent   
Name of Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/Group # \_\_\_\_\_ Insured's ID \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

## 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, advice 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, advice and treatment to another dentist.  
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 \_\_\_\_\_