# DENTAL REGISTRATION

| | | | | |
|---|---|---|---|---|
| Patients Name | | | | Date |
| Mailing Address | City | State | Zip | Home Phone |
| Birth date: Age: Sex: M F | | | Single Married Widow Divorced | |
| If child, parent or guardian's name | | | SS# | |
| Name of employer | Address | | | Business Phone |
| Occupation | Email | | | Cell Phone |

## Dental Insurance Information

| | | | |
|---|---|---|---|
| Policy Holder's Name | Relationship to Patient | SS# | DOB |
| Name of Employer | Address | | |
| Insurance Co. | Group # | Address | |

### Secondary Insurance Information

| | | | |
|---|---|---|---|
| Policy Holder's Name | Relationship to Patient | SS# | DOB |
| Name of Employer | Address | | |
| Insurance Co. | Group # | Address | |

| | |
|---|---|
| Person financially responsible for this account<br><br>Relationship to Patient | Address |

Whom may we thank for referring you?

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or guardian

All of the above are for our records only and will be considered confidential.