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 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.