Date _____

PATIENT REGISTRATION

Patient's Name _____ Birthdate _____ Sex: ☐ M ☐ F

Patient's Address _____
Street City / State Zip

Home # _____ E-mail _____

Work # _____ Cell # _____ Spouse's Cell # _____

Emergency Contact: Name _____ Home # _____ Cell # _____

Patient's Employer _____ Business Address _____

Patient's SS # _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____ Spouse's SS # _____ Spouse's Birthdate _____

Spouse's Employer _____ Employer Phone # _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name _____

Birthdate _____ SS # _____ Relationship to Patient _____

Street Address (if different than above) _____
Street City / State Zip

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name _____

Birthdate _____ SS # _____

Subscriber's Employer _____ Employer's Address _____

Insurance Company _____ Group # _____ ID # _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

IF I UNDERTAKE THIS TREATMENT, I ACCEPT THAT I AM RESPONSIBLE FOR THE TOTAL FEE REGARDLESS OF THE DENTAL INSURANCE.

▶ _____ _____
SIGNED (PATIENT, OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

▶ _____ _____
SIGNED (INSURED PERSON) DATE