Patient

Name _____
Last First Initial

Address_____
Street

_____
City State Zip

Father

Name (last, first, Ini) _____

Address_____

Phone: Home_____ Cell_____

Employer: _____

Social Security# _____/____/_____ DOB: _____

Mother

Name (last, first, Ini) _____

Address_____

Phone: Home_____ Cell_____

Employer: _____

Social Security# _____/____/_____ DOB: _____

PARENTAL STATUS

☐Single ☐Married ☐ Separated ☐Divorced ☐Widowed

Who is responsible for this account?_____

Purpose of Visit _____

_____

_____

Who may we thank for this referral?

_____

Someone to notify in case of emergency (not living with you)

Name_____

Relationship _____

Phone: Home _____ **Cell** _____

Sex ☐ **Male** ☐ **Female** **Date of Birth**_____

Nickname _____

DENTAL INSURANCE 1ST COVERAGE

Employee Name (last, first, ini.)_____

Employer _____

Name of insurance co._____

Address _____

Phone _____

Program/Policy # _____

Union Local or Group _____

Social Security # _____ / _____ /_____

DENTAL INSURANCE 2ND COVERAGE

Employee Name (last, first, ini.)_____

Employer _____

Name of insurance co._____

Address _____

Phone _____

Program/Policy # _____

Union Local or Group _____

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.
- ☐ I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- ☐ I understand that I am responsible for all costs of dental treatment.
- ☐ 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.

Patients or guardians signature _____ Date _____

Med. alert

REGISTRATION

Anest.