Patient Registration

Patient's Full Name: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birth Date: _____ SSN: _____

Marital Status: _____ Spouse's Name: _____ Birth Date: _____ SSN: _____

Your Employer Name: _____ Phone: _____ Position: _____

Spouse's Employer Name: _____ Phone: _____ Position: _____

Where may we leave a message? Circle**:** Home Cell Work Referring Dentist: _____

Primary Dental Insurance □ Please DO NOT Bill this Insurance

Policy Holder's Name: _____ Birth Date: _____ Ins. Company: _____

Patient's Ins ID: _____ Group Name: _____ Group #: _____

Secondary Dental Insurance □ Please DO NOT Bill this Insurance

Policy Holder's Name: _____ Birth Date: _____ Ins. Company: _____

Patient's Ins ID: _____ Group Name: _____ Group #: _____

Disclosure of Protected Health Information: Please list those who we may talk to about your health information. (If any)

Name: _____ Phone: _____ Relationship: _____ □ Treatment □ Billing

Name: _____ Phone: _____ Relationship: _____ □ Treatment □ Billing

Emergency Contact Name: _____ Phone: _____ Relationship: _____

PERMISSION FOR RADIOGRAPHS AND CONSULATION

To the best of my knowledge, all answers on this form are correct. I will notify the doctor of any changes in my health or medications.

I, the undersigned, consent to oral evaluation and any radiographs decided upon to be necessary or advisable in the opinion of the doctor, of which I am informed and to which I agree.

Signature: _____ Date: _____