

# Welcome

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

If child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_

Single  Married  Divorced  Widowed  Minor

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home# \_\_\_\_\_ Work# \_\_\_\_\_

Cell# \_\_\_\_\_

eMail \_\_\_\_\_

Who is responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/ Parent Social Security No. \_\_\_\_\_

Spouse/ Parent Social Security No. \_\_\_\_\_

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## Dental Insurance 1<sup>st</sup> Coverage

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Subscriber # \_\_\_\_\_

Group# \_\_\_\_\_

## Dental Insurance 2<sup>nd</sup> Coverage

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Employer Name \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Subscriber # \_\_\_\_\_

Group# \_\_\_\_\_

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## Consent:

I consent to the diagnostic procedures and treatment by the Dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain Payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's Records) to the following persons who are involved in My care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I Revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits May pay less than the actual bill for services, and that I am Financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services Not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

**Please Sign Below:**

**Patient's or Guardian's Signature:**

\_\_\_\_\_

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**REGISTRATION**