Patient Registration

WELCOME TO OUR PRACTICE

PLEASE FILL OUT COMPLETELY, THANK YOU!			
PATIENT NAME			
MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
MALE FEMALE	MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED	MINOR	
DATE OF BIRTH	SOCIAL SECURITY NUMBER		
EMPLOYER	EMAIL ADDRESS		

PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER THE AGE OF 18 OR IF SOMEONE OTHER THAN YOURSELF IS THE INSURANCE POLICY HOLDER:		
CHECK ONE: SPOUSE PARENT LEGAL GUARDIAN		
NAME		
MAILING ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	
EMPLOYER		
EMERGENCY CONTACT PERSON		
RELATIONSHIP TO PATIENT	PHONE NUMBER	

PRIMARY INSURANCE INFORMATION	
INSURANCE COMPANY	
POLICY HOLDERS NAME	
DATE OF BIRTH	
SUBSCRIBER ID NUMBER	SOCIAL SECURITY #

SECONDARY INSURANCE INFORMATION	
INSURANCE COMPANY	
POLICY HOLDERS NAME	
DATE OF BIRTH	
SUBSCRIBER ID NUMBER	SOCIAL SECURITY #

Dental Arts

I understand and agree that I am financially responsible for all charges, whether or not they are paid by insurance. All deductibles, co-pays, and non-covered services are due at the time of service. A 1.5% interest charge will be applied to that portion of the account which is not received 30 days from the statement date.

SIGNATURE:____DATE: ____________________________________