

Dental Registration

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, don't hesitate to ask for assistance. Your responses are appreciated and are completely confidential!

Name _____ Date _____ SSN _____
Address _____ City _____ State _____ Zip _____
Sex Male Female Birthdate _____ Email _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
Married Single Widowed Divorced Separated
Patients Employer/School _____ Occupation _____
Employer/School Address _____
Spouse Name _____ Employer _____ Phone (____) _____
Emergency Contact Name _____ Phone(____) _____
Whom may we thank for referring you to us? _____

Responsible Party

Name of person responsible for this account _____
Relationship to patient _____ Phone (____) _____
Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work Phone: (____) _____

Insurance Information

Name of Insured _____ Relationship to patient _____
Birthdate _____ SSN _____ Date Employed _____
Name of Employer _____ Work Phone (____) _____
Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Employer # _____
Insurance Company Address _____
How much is your deductible? _____ Have you used your insurance this year? _____
How much have you used? _____ Max. Annual Benefit? _____

Please be advised that our office does not accept secondary dental insurance. If you have a secondary insurance and wish to utilize it, we will be happy to assist you in filing the claim to receive dental benefits.

