PATIENT REGISTRATION

Patient Name: ____________________ ____________________ ______________ ______________________
Last First Middle Nickname

Patient Address: ____

City: _________________________ State: _________ Zip: ______-_____

Home Phone: (____) ____ - _____Daytime contact #: (____) ______-_______ Cell#: (____) _____-______

Email address: ____

Social Security Number: _________-_________-_________ Patient Age: _________________

Birthdate: ____/____/______ Sex: M F Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Emergency Contact: ________________________ Phone: (____)_____-__________

Patient Employer: __________________________________ Work Phone: (____)_____-__________

Employer Address: ____________________________ __________________ __________ _____________
Street City State Zip

Who is responsible for this account? __________________________ Relationship: _________________

Address: ____________________________ City: ______________ State: ______ Zip: ______-______

Social Security Number: ________-________-________ Home Phone Number: (____) _____-________

Date of Birth: _____/______/______________ Employer: ____

Employer Address: ____________________________ __________________ __________ _____________
Street City State Zip

Business Phone: (____) _____-_________ Extension or Department: _________________________

Whom may we thank for referring you to our office? ___________________________________

Method of Payment: Cash Check Debit Card Visa Master Card AMEX Discover

We offer 90 days same as cash for procedures over $300
Ask for details at the front desk.

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 to another dentist. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I authorize release of any information relating to evaluating and administering claims for insurance benefits. 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.

Patient or Guardian's Signature: ____________________________ Date: ____/____/_______

I preferto have my appointments confirmed by:
Please check all that apply: ☐ voice ☐ email ☐ Text (list your cell phone carrier)____________________________