

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

DATE OF BIRTH \_\_\_\_\_

HOW DO YOU WISH TO BE ADDRESSED \_\_\_\_\_

IF CHILD PARENTS NAME \_\_\_\_\_

### DENTAL INSURANCE 1ST COVERAGE

SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED

EMPLOYEE NAME \_\_\_\_\_

RESIDENCE - STREET \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_

TELEPHONE RESIDENCE \_\_\_\_\_ CELL # \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

BUSINESS # \_\_\_\_\_

INSURANCE # \_\_\_\_\_

PATIENT EMPLOYED BY \_\_\_\_\_

PROGRAM OR POLICY \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SPOUSE WORK # \_\_\_\_\_

SPOUSE CELL # \_\_\_\_\_

WHO WILL PAY THIS ACCOUNT \_\_\_\_\_

### DENTAL INSURANCE 2ND COVERAGE

OTHER FAMILY MEMBERS IN THIS PRACTICE \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

PATIENTS SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NUMBER \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU \_\_\_\_\_

INSURANCE # \_\_\_\_\_

PROGRAM OR POLICY \_\_\_\_\_

EMERGENCY CONTACT # \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

### PAYMENT ALTERNATIVES

- 1. Cash and personal checks are accepted as your treatments are provided.
- 2. If you have dental insurance, we want you to receive full benefit of it. Our office staff can assist you in completing your insurance forms and verifying coverage that your particular program provides. We accept assignment of your insurance payment, another service to you. This means that you are responsible for your deductible and the portion the insurance does not cover when you see the doctor. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.
- 3. American Express, Discover, MasterCard or Visa
- 4. For those of you needing an extended payment program, our office offers Wells Fargo which, when you are accepted, will allow extended small monthly payments for the treatment received.

### FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize the consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

I hereby authorize payment directly to the Dentist of the Group Insurance Benefits otherwise payable to me.

\_\_\_\_\_ Date

\_\_\_\_\_ Name

\_\_\_\_\_ Date

\_\_\_\_\_ Name

# PATIENT REGISTRATION

MED ALERT