

**Patient Registration Information**

Date \_\_\_\_\_

Name \_\_\_\_\_ Patient # \_\_\_\_\_  
First MI Last

**Welcome to our practice!**

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance-we will be happy to help!

Home address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Do you prefer to receive calls at:  Work  Home  Either

Are you:  Minor  Single  Married  Divorced  Widowed  Separated

Your or your parent/guardian's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or parent/guardian's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone \_\_\_\_\_

If you are a student, name of school/college \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of person responsible for this account \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_ SS #/SIN \_\_\_\_\_

Driver's license # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial institution \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

**Insurance Information**

Name of insured \_\_\_\_\_

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

Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date employed \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

Address of employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Employer/cert. # \_\_\_\_\_

Ins. co. address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

### Additional Insurance

Do you have any additional insurance?  Yes  No If yes, complete the following:

Name of insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS #/SIN \_\_\_\_\_ Date employed \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Employer/cert. # \_\_\_\_\_  
Ins. co. address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

### Authorization, Release, and Agreement to Pay For Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

X \_\_\_\_\_

Signature of patient or parent/guardian if minor

\_\_\_\_\_ Date

### Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

Payment in full at each appointment

\_\_\_\_\_ Cash

\_\_\_\_\_ Personal Check

\_\_\_\_\_ Credit Card \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.