

Patient Registration / Adult

WELCOME! Our goal is to help you have the healthiest, brightest smile possible. Please provide the following information as completely as you can. The better we communicate, the better we can care for your dental needs.

Patient Name		How do you wish to be addressed?		Date of Birth	
Address		City		State	Zip
Home Phone #		Social Security #		Driver's License #	
Cell Phone #					
Mark appropriate box: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered					

Account Information

Employer		Position		Work Phone #	
Spouse's Full Name					
Spouse's Employer		Position		Work Phone #	
Person responsible for account (address, if different from above)					

Insurance

Primary Dental Insurance Company _____

Name of Policyholder _____ Policy # _____

Primary Policyholders birth date _____ Social Security # _____

Secondary Dental Insurance Company _____

Name of Policyholder _____ Policy # _____

Secondary Policyholders birth date _____ Social Security # _____

If Welfare, agency and case# _____

Someone not living with you to contact in case of emergency (name and phone #):

Other family members in this practice:

How did you learn about our dental office?
If from a friend or relative, his/her name:

I authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. If additional information is needed, I authorize this office to contact the appropriate health care provider or agency to obtain such information. I understand that dental insurance is a contract between the policyholder and the insurance carrier, and that I am responsible for payment of fees for services not covered in part or in whole by the insurance carrier. I authorize payment of dental insurance benefits directly to this office. The above information is correct to the best of my knowledge. Charges may be assessed if less than 48 hours notice or no notice is given when an appointment cannot be kept.

Patient Signature _____ Date _____