



Today's Date _____

PATIENT INFORMATION

Name _____
Last First MI

How do you wish to be addressed? _____

Home Address _____
City State Zip

Phone: home _____
business _____

Social Security # _____

Birthdate _____

Marital Status
 single
 married
 divorced
 widowed

Sex
 male
 female

Are any family members patients with us? _____
Who? _____

Whom may thank for referring you? _____

Employer/Occupation _____

INSURANCE & BILLING INFORMATION

We provide the courtesy of filing your insurance claims on your behalf. Please provide us with your Insurance ID card at time of registration.

Person responsible for account _____

Relation to Patient _____

Dental Insurance Company _____

Employer Name _____

Insurance ID Number _____

Group Number _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

Date of last dental care _____

PLEASE READ AND INITIAL THE FOLLOWING

____ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

____ I understand that a fee may be charged for broken appointments as well as appointments canceled with less than 24 hour notice .

____ I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits.

____ I understand that all professional services are charged directly to the patient and that I am responsible for payment of fees including all collection/attorney fees.

Responsible party signature _____ Date _____

