

Patient Name (Last, First, Middle): _____ Title: _____
 SS #: _____ - _____ - _____ Birthdate: _____ / _____ / _____ Preferred Name: _____
 Address: _____ Town _____ State _____ Zip _____
 Home Phone: _____ Cell Phone: _____
 E-Mail Address: _____ Marital Status: S / M / D / W Sex: M / F
 Would you like a Text Message appointment reminder? Yes / No
 Employer: _____ Work Phone: _____
 Whom may we thank for referring you? _____
 Are any other family member's patients of this office? Name: _____ Relationship: _____
 Which family member is financially responsible for payment of this account? _____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____
 Address: _____ Town _____ State _____ Zip _____
 SS # (Required): _____ - _____ - _____ Birthdate (Required): _____ / _____ / _____
 Employer: _____ Work Phone: _____
 Insurance Company: _____ Group #: _____ Employee ID#: _____

Please provide us with your insurance card so we may make a copy for our records.

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____ Relationship to Patient: _____
 Address: _____ Town _____ State _____ Zip _____
 SS # (Required): _____ - _____ - _____ Birthdate (Required): _____ / _____ / _____
 Employer: _____ Work Phone: _____
 Insurance Company: _____ Group #: _____ Employee ID#: _____

PATIENT TREATMENT CONSENT

Our office will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary protected health information (PHI) to accomplish the intended purpose. I understand that this information serves as:

- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- Appointment reminders such as voicemail messages, postcards, letters or e-mail confirmations.
- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.
- I agree to be responsible for payment of all services rendered to me or to my dependents.

Patient / Parent or Guardian Signature: _____ Date: _____

It is customary to pay for professional procedures when they are rendered unless other arrangements have been made in advance. Preferred method of payment Visa/MC/Discover Check Cash

REGISTRATION