

PATIENT REGISTRATION

Today's Date:

Mr. Ms. First Name	Last Name	Date of Birth: Mo Day Year	
Home Address			
City	State	Zip	
Home Phone	Business Phone		
Soc Sec No.	Cell Phone		
Employer	Address		
Occupation			
Person Responsible for Account			
Address	City	State	Zip Code
Referred By	Your Physician	Physician's Phone #	
Purpose of Call			
Remarks			

DENTAL INSURANCE INFORMATION

Insured's Name	Relationship to Patient				Sex		Insured Date of Birth		
	Self	Spouse	Child	Other	M	F	Mo	Day	Year
Soc. Sec. No.	If Full Time Student School				City				
Policy No.									
Primary Insurance Carrier									
Address									
City	State				Zip				

AUTHORIZATION & RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize my dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or 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 my dependents. If my account is referred to an attorney for collection, I agree to pay all attorney's fees and court cost. Any account balance older than 90 days will be subject to a monthly finance charge of 1.5% or 18% annually.

Signature of Patient or Parent if Minor