PATIENT REGISTRATION

Today's Date: _____

Mr. / Ms. / Dr.			DATE OF BIRTH	
HOME ADDRESS			HOME PHONE	
CITY	STATE	ZIP	BUSINESS PHONE	
SOCIAL SECURITY #			CELL PHONE	
E-MAIL ADDRESS				
EMPLOYER			OCCUPATION	
PERSON RESPONSIBLE FOR ACCOUNT				
ADDRESS	CITY AND STATE		ZIP CODE	
REFERRED BY	YOUR PHYSICIAN		PHYSICIAN'S PHONE #	

POLICY HOLDER'S DENTAL INSURANCE INFORMATION

POLICY HOLDER'S NAME				POLICY HOLDER'S DATE OF BIRTH		
SOCIAL SECURITY #			ID #		GROUP #	
RELATIONSHIP TO PATIENT:	SELF	SPOUSE	PARENT / GUARDIAN	SEX:	M	F
POLICY HOLDER'S EMPLOYER:						
PRIMARY INSURANCE CARRIER:						
ADDRESS:						
CITY AND STATE:				ZIP CODE:		

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 examination 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.

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Signature of patient or parent if minor