**Registration**

To help us meet all your healthcare needs, please fill out the form completely.

## Patient information *(Confidential)*

First Name:______________________ MI:________________ Last Name: ________________________

Nickname: ______________________ **Birthdate:**____________ Sex: Male / Female SS#: _____________

Address: _______________________ City: _______________ State:____________ Zip: _____________

Cell Phone:______________________ Home: _____________ Email: ___________________________

Employer: _____________________________________ Work Phone: ________________________

General Dentist: __________________ Referred by: __________________ Physician: _________________

Have you ever been a patient of our practice? Yes___ No___ Unsure___

## Emergency Contact

Emergency Contact Name: ______________________ Is this your: Spouse____ Parent____ Child____ Other____

Cell: ________________________ Home: ________________________ Work: _____________________

## Who will be responsible for your account? *(If Self, skip to next section)*

Self___ Spouse___ Father___ Mother___ Other__________________

First Name:______________________ MI:________________ Last Name: ________________________

Nickname: ______________________ Birthdate: ____________ Sex: Male / Female SS#: _____________

Address: _______________________ City: _______________ State:____________ Zip: _____________

Cell Phone:______________________ Home: _____________ Email: ___________________________

Employer: ___________________________________________ Work Phone: ________________________

Have they ever been a patient of our practice? Yes___ No___ Unsure___

## Primary Dental Insurance Information

Primary Insured's Name_________________________

Sex: Male / Female Relation: ____________________

SS#: ______________________________________

DOB:______________________________________

Insurance Carrier: ____________________________

Group Name: ________________________________

Group #: ___________________________________

ID #: ______________________________________

## Secondary Dental Insurance Information

Secondary Insured's Name______________________

Sex: Male / Female Relation: ___________________

SS#:______________________________________

DOB: _____________________________________

Insurance Carrier: ___________________________

Group Name:_______________________________

Group #:___________________________________

ID #:______________________________________

## Authorization

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any collection costs if this office determines they are necessary. I understand this office will assist me in submitting claims to my insurance carrier, but I am responsible for any services not covered. I authorize release of my records as deemed necessary to third party payers, other professionals or other health care operations. I authorize use of this signature for all insurance submissions. I have received a copy and understand the "Notice of Privacy Practices". I understand that I am giving my consent for use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

X______________________________________ Date: ______________________________________

Signature of Patient or Responsible Party