

**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:

Home Phone: Mobile: 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\_\_\_\_ Father\_\_\_\_ Mother\_\_\_\_ Other\_\_\_

Home: Mobile: 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:

Home Phone: Mobile: Email:

Employer: Work Phone:

Have they ever been a patient of our practice? Yes\_\_\_ No\_\_\_ Unsure\_\_\_

**Primary Dental Insurance Information Secondary Dental Insurance Information**

Primary Insured’s Name Secondary Insured’s Name

Sex: Male / Female Relation: Sex: Male / Female Relation:

SS#: SS#:

DOB: DOB:

Insurance Carrier: Insurance Carrier:

Group Name: Group Name:

Group #: Group #:

ID #: 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 my insurance company to make insurance payments directly to this dental office for services rendered. 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