

Personal Information	Name		Last	First	Middle		
	Address		Street or P.O. Box #	City	State	Zip Code	Phone No. Home: Work:
	Pager # :		Cell Phone:		Email Address:		
	Age: Yrs.	Birth Date Mo. Day Year		(Male _____ Female _____)		<input type="checkbox"/> Married <input type="checkbox"/> Unmarried <input type="checkbox"/> Separated	
	Social Security No. (if child, parents)				Drivers's License No.		
	Occupation		Employer		How long employed?		Address & Phone No.
	Person responsible for bill		Age	Address		Relationship	Social Security No.
							Driver's License No.
	Occupation		Employer		How long employed?		
	Employer Address & Phone No.						

Insurance Information	Insured Person's Full Name		Date of Birth			
	Social Security Number		Relationship to Patient		Work Phone	
	Insurance Company Name		Group or Union Name		Group or Local Number	
	Employer's name			Full Address of Employer		

Getting to Know You	1. Why did you select our practice? _____ _____	5. When was your last dental visit? _____ 6. When was the last time you had complete dental radiographs taken? Name & Address of Last Dentist: _____ _____
	2. Whom may we thank for referring you? _____ _____	7. Have you ever had any teeth removed? _____ How long have these teeth been missing? _____ Have these teeth been replaced? _____ How? <input type="checkbox"/> Bridge <input type="checkbox"/> Partial <input type="checkbox"/> Denture <input type="checkbox"/> Implants
3. Is another member of your family or relative a patient in our practice? _____	4. Person to contact for emergency: Phone: _____	

Getting to Know You	Please check appropriate box: <input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay for entire treatment plan in full, in advance. <input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided. <input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment; another service to you.	This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us. <input type="checkbox"/> 4. Mastercard, Visa, Discover <input type="checkbox"/> 5. For long term or extended payments, we offer a healthcare financing program, which when your are accepted, will allow extended small monthly payments for the treatment received.

FOR ALL PATIENTS

hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he or she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

Signature of Responsible party

Relationship

Date

PATIENT REGISTRATION