

The Offices of Fredrick M. Vega, D.D.S., P.C. & Associates

PATIENT REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status _____ DOB _____ SS # _____ Drivers License _____

E-mail _____ I would like to receive correspondences via e-mail

Employer _____ Work Phone _____

Employer's Address _____

Are you experiencing any dental problems at this time? If so, what? _____

How long has it been since you have seen a dentist? _____ What was done then? _____

How did you hear about us? _____ Do you have dental insurance? _____

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following:

Primary Insurance Information: Name of Insurance Company _____

Address _____ Phone Number _____

Name of Insured _____ SS # _____ DOB _____

Employer Name, Address & Phone _____

Policy Number _____ Group Number _____ Name of Insured _____

Relationship to Insured: Self Spouse Child Other _____

Secondary Insurance Information: Name of Insurance Company _____

Address _____ Phone Number _____

Name of Insured _____ SS # _____ DOB _____

Employer Name, Address & Phone _____

Policy Number _____ Group Number _____ Name of Insured _____

Relationship to Insured: Self Spouse Child Other _____

I hereby authorize and request the performance of dental services for myself by Dr. Fredrick Vega and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Vega and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

(Signature)

(Date)