

# Patient Registration

Date \_\_\_\_\_

## Patient Information:

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

If Child, Parent's Name \_\_\_\_\_ Patient Social Security No. \_\_\_\_\_

Marital Status \_\_\_\_\_ Referred by \_\_\_\_\_ If Child, School Name \_\_\_\_\_

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## Responsible Party Information:

Responsible Party Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Social Security No \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_

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## Employer:

Employer \_\_\_\_\_ Position \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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## Insurance Coverage:

### Primary Insurance:

Insured's Name \_\_\_\_\_ Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_

ID No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Union Local or Group \_\_\_\_\_

### Secondary Insurance:

Insured's Name \_\_\_\_\_ Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_

ID No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Union Local or Group \_\_\_\_\_

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## Consent and Assignment:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my dependent's) records to carry out treatment, to obtain payment, and for those activities that are related to treatment and payment. My consent to this disclosure shall be effective until I revoke it in writing. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services and that I am financially responsible for payment in full of my (or my dependent's) account and that this applies regardless of any insurance coverage that I may have. I understand and agree that a finance charge of 1.5% per month (18% APR) will be assessed on all balances over 120 days old.

I acknowledge that the above questions have been answered truthfully and to the best of my knowledge. I will not hold the dentist or any member of the staff responsible for any omissions or errors made on my part in completing this form.

I certify that I have read, understand, and accept the provisions stated above.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date