REGISTRATION

DATE _____

PATIENT'S NAME _____
LAST FIRST M.I.

BIRTHDATE _____ AGE _____ ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCE

NAME OF SPOUSE _____

IF A CHILD, PARENT'S NAME _____

RESIDENCE _____
STREET CITY STATE ZIP

BUSINESS ADDRESS _____

TELEPHONE: RESIDENCE _____ BUSINESS _____ CELL _____

EMAIL ADDRESS _____

PATIENT EMPLOYED BY _____ PRESENT POSITION _____HOW LONG HELD _____

SPOUSE EMPLOYED BY _____ PRESENT POSITION _____HOW LONG HELD _____

REFFERED BY _____

WHO WILL PAY THIS ACCOUNT _____

PURPOSE OF CALL _____

PATIENT'S SOCIAL SECURITY NO. _____ DRIVER'S LICENSE NO. _____

SPOUSE'S SOCIAL SECURITY NO. _____ BIRTHDATE _____

NAME AND ADDRESS OF DENTAL INSURANCE COMPANY:

PRIMARY	SECONDARY
_____	_____
_____	_____
POLICY # _____	POLICY # _____

To avoid any misunderstanding, office exams and treatments are due and payable in full at the time services are rendered unless previous arrangements have been made. An itemized bill will be provided to file your Insurance Claim for office charges. We will file your insurance for pre-determinations and more detailed procedures. This is done as a courtesy to you and you are responsible for the entire balance. Your Insurance Policy is a contract between you and your Insurance Carrier to establish why they have not paid or why they paid a different amount than expected.

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointments without prior notifcation of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)