PATIENT

NAME: ______________________ DATE: __________ DATE OF BIRTH: __________ M ___ F___

IF CHILD PARENT NAME:

____

HOW DO YOU WISH TO BE ADDRESSED?

____

PHONE: (BEST NUMBER TO CONFIRM)

HOME: ________________ CELL: ______________

MAILING ADDRESS:

____

CITY: ______________ STATE: _______ Zip: _________

PATIENT EMPLOYED BY:

____

RESPONSIBLE PARTY: ______________________

INSURANCE CARRIER SS#: ______________________

SPOUSE NAME: ______________________

SPOUSE EMPLOYED BY: ______________________

METHOD OF PAYMENT:

INSURANCE _______ CREDIT CARD ________ CASH _______

OTHER MEMBERS IN THIS PRACTICE: ______________________

____

WHO MAY WE THANK FOR THIS REFERRAL:

____

IN CASE OF EMERGENCY: ______________________

____

Dental Insurance Coverage

EMPLYEE NAME ______________________

EMPLOYEE DATE OF BIRTH ______________________

EMPLOYER ______________________

NAME OF INSURANCE ______________________

ADDRESS ______________________

____

TELEPHONE ______________________

GROUP # ______________________

MEMBER ID/ SSN ______________________

OFFICE USE ONLY

EXAM: D0140 __________ D0120 & D0150 __________

PANO/FMX ______________________

BWX ______________________

PROPHY ______________________

GROSS DEBRI. ______________________

PERIO MAINT. ______________________

SRP ______________________

FLUORIDE ______________________

SEALANTS ______________________

DEDUCTIBLE ________ MAX __________

PREV __________ PERIO __________

BASIC __________ ENDO __________

MAJOR __________ EXTR: D7140 _____ D7210 _____

EFF DATE __________ RENEW __________

N2O _____ IV ______ NG ______ IMPLANT _______

RELEASE

I authorize the dentist and all staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I hereby agree to pay all costs of collection (including attorney fees), should any amount due hereunder be turned over for collection.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE ______________________________ DATE __________

REGISTRATION