Date:________________________

REGISTRATION FORM

Name:____ Soc. Sec. #: __________________

Last First Middle

Street Address:____ Date of Birth:____________________

City:_______________________ State:___________ Zip:_____________ Drivers License:________________

Cell Phone:______________ Home Phone:_______________ Business Phone:_________________ext._____

E-mail:____________________________________Emergency Contact:______________________________

Relationship:_______________________________________ Phone #:________________________________

Pharmacy name and number: ____

Which type of account would you prefer? Individual: ❑ Family: ❑ Individual

Person responsible for bill:____

Whom may we thank for referring you to this office?____

- Name of your **PRIMARY DENTAL** Insurance Co: ____

Name of card holder: ___________________________Relationship to patient__________________________

Soc. Sec #:____________________ Date of birth:__________________ ID#:___________________________

Primary Employer:____

- Name of your **SECONDARY DENTAL** Insurance Co: ____________________________________

Name of card holder: ___________________________Relationship to patient_________________________

Soc. Sec #:____________________ Date of birth:__________________ ID#:___________________________

Primary Employer:____

I confirm that I have entered the above information accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I consent to any and all dental treatments recommended to maintain my oral health. I authorize and request my dental insurance company to pay directly to the dentist. I understand my dental benefits and am aware that I am responsible for payment of any and all services not covered by dental insurance. I understand that I am responsible for payment of all services rendered on my behalf and on the behalf of my dependants. Date:______________

Signature of Patient (or parent if minor):____

NEW PATIENTS ONLY:

Name of last Dentist:____

Phone Number:_________________________________ Date of last Dental Exam: ______________________

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(860) 456-2906
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