REGISTRATION FORM

PATIENT'S INFORMATION	WHOM MAY WE THANK FOR THIS REFERRAL
LAST	PATIENT'S SOCIAL SECURITY NUMBER
FIRST M. I.	SPOUSE'S SOCIAL SECURITY NUMBER
DATE OF BIRTH	EMERGENCY CONTACT NOT LIVING WITH YOU
SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐	**DENTAL INSURANCE**
HOW DO YOU WISH TO BE ADDRESSED	EMPLOYEE NAME
STREET	EMPLOYEE DATE OF BIRTH
CITY STATE ZIP CODE	EMPLOYER
HOME CELL WORK	NAME OF INSURANCE
EMAIL	POLICY NUMBER
EMPLOYER/COMPANY NAME	INSURANCE CO. PHONE NUMBER
POSITION TIME IN POSITION	SUBSCRIBER I.D.
DAYS AVAILABLE FOR TREATMENT M ☐ T ☐ W ☐ TH ☐ F ☐	GROUP NUMBER

CONSENT

I undestand and agree that, regardless of my insurance status, the responsability for payment for all dental services provided in this office for myself and my dependents are mine, due and payable at the time services are rendered unless prior financial arrangements have been made. I also understand that all X-rays and diagnostic aids are the property of the dental office and that copies if requested will be made available to me for a reasonable FEE as set by this office.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS INSURANCE CLAIM:

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE