**Patient Registration**

Patient Name: _____ Date: _____

Preferred Name: _____ S.S. #: _____

Address: _____ Birth date: _____ Age: _____

City, State, Zip: _____ Home Phone: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Minor Cell Phone: _____

Patient Employer/ School: _____ E-mail_____

Address: _____ Part or Full Time: _____

Occupation: _____ Work phone: _____

Preferred method of contact: Phone; □ Home ☐ Cell □ Work ☐ E-mail ☐ Text

Who is responsible for this account? _____ Relation: _____

Whom may we thank for referring you? (Patient/Website/Employee etc.) _____

**Your Spouse:**

Name: _____

Birth Date: _____

S.S. #: _____

Employer: _____

Work Phone: _____

**In Case of Emergency, Contact**
(someone who does not live in your household)
Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

**Dental Insurance:**
Employee Name: _____
Subscriber's Name: _____

Relation to Patient: _____ DOB: _____

Insurance Co. _____

Subscriber ID or S.S. #: _____

Group #: _____ Phone: _____

**Is patient covered by additional insurance? O Yes O No**

Subscriber Name: _____ Relation: _____

Insurance Co. _____ DOB: _____

Subscriber ID or S.S. #: _____

Group #: _____ Phone: _____

**Authorization and Release**

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance claims.

_____ _____

(Signature of patient or parent of Minor) (Date)