PATIENT REGISTRATION FORM

Patient's Name: _____
Last First Initial Date of Birth

Nickname: _____ ❑Male ❑Female ❑Single ❑Married ❑Other

If Child: Parent's Name:

_____

Address: _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____

Cell Phone # _____

Email _____

Patient/Parent Employer _____

Present Position _____

How long held _____

Spouse/Parent Name _____

Spouse Employer _____

Present Position _____

How long held _____

Who is Responsible for this Account _____

Drivers License # _____

Other Family members in this practice _____

_____

Whom may we thank for this referral?
Current Patient(name) _____
Google Ad __Google Search __Facebook __Instagram
__Billboard Cambridge __ Billboard Fort __ Newspaper
__Radio __Mailer __Sponsorship Other(list)_____

Patient/Parent Social Security # _____

Spouse/Parent Social Security # _____

Someone to notify in case of emergency (not living with you)
_____

DENTAL INSURANCE PRIMARY COVERAGE

Employee Name:_____D.O.B._____
_____
Employer Name:_____Years:_____

Name of Insurance Co.:_____

Address _____

Phone _____

Policy # _____

SS # _____

DENTAL INSURANCE SECONDARY COVERAGE

Group or Union Local _____

Employee Name_____ D.O.B _____

Employer Name_____ Yrs. _____

Name of Insurance Co. _____

Address _____

_____

Phone _____

Policy # _____

_____

SS#_____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits 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, and that I am financially responsible for payment in full to 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, by my dental care payor.

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

Patient or Guardian's signature:

_____Date:_____