

PATIENT'S NAME \_\_\_\_\_ NICKNAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 PATIENT'S PHONE \_\_\_\_\_ SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS# \_\_\_\_\_  
 PATIENT'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 FATHER'S NAME \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 FATHER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 FATHER'S EMPLOYER \_\_\_\_\_ PRESENT POSITION \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
 FATHER'S TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 MOTHER'S NAME \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
 MOTHER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 MOTHER'S EMPLOYER \_\_\_\_\_ PRESENT POSITION \_\_\_\_\_ HOW LONG? \_\_\_\_\_  
 MOTHER'S TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ E-MAIL \_\_\_\_\_  
 WHO IS RESPONSIBLE FOR THIS ACCOUNT? \_\_\_\_\_ METHOD OF PAYMENT:  Insurance  Credit Card  Cash  
 PURPOSE OF TODAY'S VISIT? \_\_\_\_\_ WHO MAY WE THANK FOR THIS REFERRAL? \_\_\_\_\_  
 OTHER FAMILY MEMBERS IN PRACTICE \_\_\_\_\_  
 RELATIVE/FRIEND TO NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**DENTAL INSURANCE 1ST COVERAGE**

EMPLOYEE NAME \_\_\_\_\_  
 EMPLOYEE DATE OF BIRTH \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 EMPLOYER'S ADDRESS \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_ POLICY # \_\_\_\_\_  
 SOCIAL SECURITY NO. \_\_\_\_\_

**DENTAL INSURANCE 2ND COVERAGE**

EMPLOYEE NAME \_\_\_\_\_  
 EMPLOYEE DATE OF BIRTH \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 EMPLOYER'S ADDRESS \_\_\_\_\_  
 INSURANCE CO. \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_ POLICY # \_\_\_\_\_  
 SOCIAL SECURITY NO. \_\_\_\_\_

**RELEASE:**

I authorize the dentist 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 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 payer of my dental benefits may pay less than the actual bill for services.  
 I understand I am responsible for payment of services not paid, in whole or in part by my dental payer.  
 I attest to the accuracy of the information on this page.

PARENT'S/GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**REGISTRATION**