CONFIDENTIAL PATIENT REGISTRATION

Welcome to our dental practice! Please complete the following important information.

Contact Information:

Mr./Mrs./Ms/Miss/Dr. (please circle one)

Surname:_____ First name:_____ Middle initial:_____

Preferred name:_____ Gender: _____ Birthdate M/D/Y: _____

Address:_____

Home phone:_____ Cell phone:_____ Work phone: _____

Preferred daytime contact number: Home ☐ Cell ☐ Work ☐ Email: _____

I would like text reminders for my appointments: Yes ☐ Please keep me up-to-date with e-mail newsletters: Yes ❑.

How did you hear about our office? _____

Emergency contact:

Name:_____ Relationship to patient: _____

Home phone:_____ Cell phone:_____ Work phone: _____

If the patient is a minor and/or a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care:

Name:_____ Relationship to patient: _____

Address: _____

Home phone:_____ Cell phone:_____ Work phone: _____

Preferred daytime contact number: Home ☐ Cell ☐ Work ☐ Email: _____

Patients with dental insurance:

1) Insurance company: _____Policy Number _____ Subscriber ID: _____
   Subscriber name: _____Subscriber birthdate: _____
2) Insurance company: _____Policy Number _____ Subscriber ID: _____
   Subscriber name: _____Subscriber birthdate: _____

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

_____ _____

Signature of patient or parent/guardian of minor Date