



PATIENT REGISTRATION

Patient Name	
Birth date	Sex M / F
Address	
City	Zip
Home Phone	Cell Phone
Work Phone	Email
Social Security #	Marital Status S / M

Emergency Contact	
Phone	Relationship

FOR PATIENTS COVERED BY INSURANCE

Primary Insurance:	
Subscriber's Name	
Subscriber's Birth date	
Subscriber's Social Security #	
Subscriber's Employer	Group#

Secondary Insurance:	
Subscriber's Name	
Subscriber's Birth date	
Subscriber's Social Security #	
Subscriber's Employer	Group#

The above information is accurate and complete to the best of my knowledge, and is only for the use in my treatment, billing and processing of insurance for benefits for which I am entitled. I authorize and request my dental insurance carrier to pay my benefits directly to the dentist. I understand that my dental insurance may pay less than the total actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Account balances unpaid for 25 days after date of service will be subject to a 1% monthly finance charge. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney's fees.

Signature of Patient or Responsible Party _____ Date _____