Patient Registration Form

Patient _____
First Name Initial Last Name
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Email Address _____ DOB _____ SS# _____

Emergency Contact
Name _____ Relation _____
Phone number _____ Phone number _____

General Dentist
Name _____ Phone _____

Employer Information of Subscriber Insurance
Employers Name _____ Phone number _____
Address _____
City _____ State _____ Zip _____

Insurance Information
Subscribers Name _____ Social Security _____ DOB _____
Insurance Company _____ Plan Name _____

Secondary Insurance Information
Subscribers Name _____ Social Security _____
Insurance Company _____ Plan Name _____

Please read the following and sign:

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Your portion of the bill will be due at time of service.

If your insurance has not paid within 60 days from the date of service, we will look to your for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party. I understand that, due to any false information, I will be subject to criminal prosecution

_____ _____
Date Signature of patient (responsible party of minor)