REGISTRATION

Patient_____M or F (Circle)
FIRST INITIAL LAST

Home Address_____
STREET AND NO. CITY/STATE ZIP

Home Phone_____ Business Phone_____

E-mail address_____

Social Security Number_____Birthdate _____

Employed by_____Occupation_____

Name of Spouse/Parent(Circle)_____

Nearest Relative (Not living @ same address as patient)_____

Address& phone of Nearest Relative_____

INSURANCE INFORMATION

☐ PLEASE CHECK HERE IF YOU DO NOT HAVE DENTAL INSURANCE

Subscriber Name_____Birthdate_____

Employed By_____ SS#_____

Insurance Company_____ Group#_____

Insurance Company Address_____

SECONDARY INSURANCE (IF APPLICABLE)

Subscriber Name_____Birthdate_____

Employed By_____SS#_____

Insurance Company _____Group#_____

Insurance Company Address_____

As a convenience to you, we will submit all claims directly to your insurance company. However, insurance is a contract between you and your insurance company. Regardless of coverage, you are responsible for the payment of your account within 90 days. We cannot accept responsibility for collecting insurance claims or for negotiating disputed claims.

Signature of Responsible Party_____Date_____