

MR. MRS. MISS MS. DR. REV.

PATIENT'S NAME \_\_\_\_\_  
Last First Initial

IF CHILD:  
PARENT'S NAME \_\_\_\_\_  
Last First Initial

WOULD YOU LIKE US TO CALL YOU BY YOUR:

FIRST NAME  LAST NAME  NICK NAME \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

RESIDENCE - STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TELEPHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

BUSINESS TELEPHONE \_\_\_\_\_

PATIENT/PARENT EMPLOYED BY \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

PATIENT/PARENT SOCIAL SECURITY NO. \_\_\_\_\_

SPOUSE NAME \_\_\_\_\_

SPOUSE EMPLOYED BY \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

BUSINESS TELEPHONE \_\_\_\_\_

PRESENT POSITION \_\_\_\_\_ HOW LONG HELD \_\_\_\_\_

SPOUSE SOCIAL SECURITY NO. \_\_\_\_\_

OTHER FAMILY MEMBERS IN THIS PRACTICE \_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL \_\_\_\_\_

\_\_\_\_\_

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU.

NAME \_\_\_\_\_

TELEPHONE \_\_\_\_\_

**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 (or my child's) health care, advice and treatment to another dentist.  
I understand that I am responsible for all costs of dental treatment.  
I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me.  
I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

PATIENT: MALE  FEMALE

**DENTAL INSURANCE 1ST COVERAGE**

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ #YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY# \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

IF STUDENT, NAME OF SCHOOL \_\_\_\_\_

CITY OF SCHOOL \_\_\_\_\_

**DENTAL INSURANCE 2ND COVERAGE**

EMPLOYEE NAME \_\_\_\_\_

EMPLOYEE DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ #YRS. \_\_\_\_\_

NAME OF INSURANCE CO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE \_\_\_\_\_

PROGRAM OR POLICY# \_\_\_\_\_

UNION LOCAL OR GROUP \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

MED. ALERT

**REGISTRATION**