CONFIDENTIAL PATIENT REGISTRATION **Dr.**_____

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:** Female ___ Male ___ **Birthdate** M/D/Y: _____

Address:_____

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

Preferred daytime contact number: (√) H___ C___ W___ **Email:**_____

Emergency contact: _____ **Relationship to patient:** _____

Daytime phone:_____ **Cell phone:**_____

Responsible Party – re treatment and financial considerations (Please complete all information if different from above)

Name:_____ **Relationship to patient:**_____

Address: _____

Home phone:_____ **Cell phone:**_____

Work phone:_____ **Preferred daytime contact number:** (√) H___ C___ W___

Email:_____

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

_____

Insurance Information

Policy holder:_____**Relationship to patient:**_____ **Birthdate** M/D/Y:_____

Employer:_____**Work phone:**_____ E**mail:**_____

Address: _____

Insurance company_____**Group/Policy #:**_____**Certificate/Div/ID #:**_____

Coverage: Basic:_____**% limit: $**_____ **Major:**_____**% limit: $**_____ **Ortho:**_____**% limit: $**_____

Secondary policy

Policy holder:_____**Relationship to patient:**_____ **Birthdate** M/D/Y:_____

Employer:_____**Work phone:**_____ E**mail:**_____

Address: _____

Insurance company_____**Group/Policy #:**_____**Certificate/Div/ID #:**_____

Coverage: Basic:_____**% limit: $**_____ **Major:**_____**% limit: $**_____ **Ortho:**_____**% limit: $**_____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

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