Patient Registration Form

Phone: _____ Home Phone: _____ Cell

Phone: _____ Work S.S. #: _____ Email: _____

Name: _____
(Last) (First) (Middle)

Address: _____ City: _____ Zip: _____

Birthdate: _____ Sex: ____ Height: _____ Weight: _____ Marital Status: _____

Who to contact in an emergency?: _____ Phone: _____

How did you hear of us? Yellow Pages _____ Bell _____

Office Sign _____ Donnelley _____ Friend _____ Other _____

Patient Business Information

Company: _____ Company: _____

Address: _____ Address: _____

Department: _____ Department: _____

Phone: _____ Phone: _____

Can we call to confirm at your office? Yes No Can we call to confirm at your office? Yes No

Insurance Information

Dental Insurance Company: _____

Plan Number: _____ Plan Name: _____

Guarantor Name: _____ Guarantor S.S. #: _____
(Insured)

Guarantor Address: (If different from above) _____
(Insured)

Guarantor Birthday: _____
(Insured)

Additional Policy: _____

Policy Number: _____ Plan Name: _____

Appointments: A charge will be made for failed or cancelled appointment without prior notification of 24 hours.
Once an appointment has been made, please remember this time has been reserved for you.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to the above named dentist of the group insurance benefits, otherwise payable to me.

Signed _____ **Date** _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any information necessary to process any insurance claim.

Signed _____ **Date** _____
(Subscriber)