PATIENT'S NAME _____ NICKNAME _____ TODAY'S DATE _____

PATIENT'S PHONE _____ SEX _____ BIRTHDATE _____ SS# _____

PATIENT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY INFORMATION: ☐ LEGAL PARENT ☐ LEGAL CUSTODIAN ☐ LEGAL GUARDIAN ☐ LEGAL FOSTER PARENT

FATHER'S NAME _____ MARITAL STATUS _____ SS# _____ BIRTHDATE _____

FATHER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S EMPLOYER _____ PRESENT POSITION _____ HOW LONG? _____

FATHER'S TELEPHONE: HOME _____ WORK _____ E-MAIL _____

CELL PHONE _____ WOULD YOU LIKE TO RECEIVE APPOINTMENT CONFIRMATION VIA TEXT ☐ YES ☐ NO

MOTHER'S NAME _____ MARITAL STATUS _____ SS# _____ BIRTHDATE _____

MOTHER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOTHER'S EMPLOYER _____ PRESENT POSITION _____ HOW LONG? _____

MOTHER'S TELEPHONE: HOME _____ WORK _____ E-MAIL _____

CELL PHONE _____ WOULD YOU LIKE TO RECEIVE APPOINTMENT CONFIRMATION VIA TEXT ☐ YES ☐ NO

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ PAYMENT METHOD: ☐ Insurance ☐ Credit Card ☐ Cash ☐ CareCredit

PURPOSE OF TODAY'S VISIT? _____ WHO MAY WE THANK FOR THIS REFERRAL? _____

OTHER FAMILY MEMBERS IN PRACTICE _____

EMERGENCY CONTACT OTHER THAN PARENT _____

RELATIONSHIP TO PATIENT _____ HOME PHONE _____ CELL PHONE _____

## DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

EMPLOYER _____

INSURANCE CO. _____

MEMBER ID# _____

GROUP # _____

PHONE NUMBER _____

## DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

EMPLOYER _____

INSURANCE CO. _____

MEMBER ID# _____

GROUP # _____

PHONE NUMBER _____

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 child's health care, advice and treatment to another dentist.

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

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
I understand I am responsible for payment of services not paid, in whole or in part by my dental payer.

I attest to the accuracy of the information on this page.

PARENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

# REGISTRATION

FORM 122155 R/07/13 ITEM 8101