REGISTRATION FORM

Please complete the following section about the patient:

NAME: ______________________ NICKNAME: ______________________

DATE OF BIRTH: ______________________ SOCIAL SECURITY NUMBER: ______________________

MAILING ADDRESS: ______________________ ST: ________ ZIP: ______________________

HOME PHONE: ______________________ WORK PHONE: ______________________

MAY WE CALL WORK TO CONFIRM APPOINTMENTS? [ ] YES [ ] NO

Please complete the following section if you have dental insurance:

NAME OF THE INSURED: ______________________ DATE OF BIRTH: ______________________

WHERE DOES INSURED WORK? ______________________ SS#: ______________________

INSURED'S MAILING ADDRESS IF DIFFERENT THAN PATIENT'S:

______________________ ST: ________ ZIP: ______________________

INSURED'S HOME PHONE: ______________________ INSURED'S WORK PHONE: ______________________

MAY WE CALL WORK TO CONFIRM APPOINTMENTS? [ ] YES [ ] NO

NAME OF INSURANCE COMPANY: ______________________ CERT/POLICY/GRP # ______________________

PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

HAVE YOU USED YOUR DENTAL INSURANCE IN THE LAST 12 MONTHS? [ ] YES [ ] NO

Please complete the following section if you have medical insurance:

NAME OF THE INSURED: ______________________ DATE OF BIRTH: ______________________

WHERE DOES THE INSURED WORK? ______________________ SS#: ______________________

NAME OF THE INSURANCE COMPANY: ______________________ CERT/POLICY/GRP#: ______________________

NAME OF PHYSICIAN: ______________________ PHONE: ______________________

PATIENT'S RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

Please complete the following section if the patient is not financially responsible or insured:

NAME OF PERSON TO BE BILLED: ______________________ DATE OF BIRTH: ______________________

MAILING ADDRESS: ______________________ ST: ________ ZIP: ______________________

SOCIAL SECURITY NUMBER: ______________________ RELATIONSHIP TO PATIENT: ______________________

HOME PHONE: ______________________ WORK PHONE: ______________________

We would like to know:

Whom should we notify in case of emergency? ______________________

Relationship to patient: ______________________ Phone: ______________________

Whom may we thank for referring you? ______________________