Registration

(For new patients only: How did you hear about our clinic?
Insurance ____ Word of Mouth-Name: _____ Saw Building ____ Phonebook ____
Facebook ____ Church ___ Website ____ Other ____)

Name_____ ☐M ☐F
(First) (Middle) (Last) (Sex)

Address_____
(Street) (City) (Zip)

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

Employed by_____ Work Phone (_____)_____-_____

Date of Birth _____ Patient SS# _____

Emergency Contact _____ Phone (_____)_____-_____

Relationship _____

Primary Insurance
Policy Holder_____
Home Address _____
Phone Number _____
Date of Birth_____
Relationship to Patient_____
Employer_____
Group #_____
SS#_____
ID#_____
Name of Insurance
Co._____
Phone # (_____)_____-_____
Marital Status of Policy Holder _____

Secondary Insurance
Policy Holder_____
Home Address _____
Phone Number _____
Date of Birth_____
Relationship to Patient_____
Employer_____
Group #_____
SS#_____
ID#_____
Name of Insurance
Co._____
Phone # (_____)_____-_____
Marital Status of Policy Holder _____

I hereby authorize payment directly to Dr. B. Dentistry for the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. B. Dentistry to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge and I have been made aware of this office's Notice of Privacy Practices.

_____ _____
(Signature of Patient, Parent, or Guardian) (Date)

(Optional) I authorize Dr. B. Dentistry to use my mobile phone number and/or email address for appointment reminders.

- Your mobile number (_____)_____. Messages will be sent from 390-16.
- Your email address _____. Emails will be sent from "Dr. B. Dentistry."

Expiring Insurance Reminders, Post-op Instructions, Reviews and Surveys, In-office Promotions & Newsletters, and Treatment Plan Follow-Ups may also be emailed. Please alert a team member if you would rather not receive any of these notifications.

Because _____ is a minor, it is necessary that a signed permission be obtained from a parent or guardian before any necessary dental service can be started and accomplished by Dr. B. Dentistry. Furthermore, I will be responsible for any fees incurred today for this child's dental treatment. Authorization is hereby granted.

Father _____ Work Phone (____)____-_____

Employed by _____ Address _____

Mother _____ Work Phone (____)____-_____

Employed by _____ Address _____

_____ _____

(Signature of Parent or Guardian) (Date)

_____ _____

(Signature of Parent or Guardian) (Date)

_____ _____

(Signature of Parent or Guardian) (Date)

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(Signature of Parent or Guardian) (Date)

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