Registration

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

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

Address____
(Street) (City) (Zip)

Home Phone (_______)________-_______________ Cell Phone (_______)_________-_________________

Email Address ____

Employed by_______________________________________ Work Phone (_______)_________-_____________

Date of Birth ___________________________________ Patient SS# __________________________________

Preferred Appointment Times: ☐AM ☐PM

Emergency Contact ____________________________________ Phone (_______)_______-_____________

Relationship ____

Primary Insurance	Secondary Insurance
Policy Holder_____________________________________	Policy Holder_____________________________________
Home Address ____________________________________	Home Address ____________________________________
Phone Number ___________________________________	Phone Number ___________________________________
Date of Birth_____________________________________	Date of Birth_____________________________________
Relationship to Patient__________________________	Relationship to Patient__________________________
Employer____	Employer____
Group #____	Group #____
SS#____	SS#____
ID#____	ID#____
Name of Insurance Co.______________________________	Name of Insurance Co.______________________________
Phone # (________)________-_________________________	Phone # (________)________-_________________________
Marital Status of Policy Holder __________________	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 and/or emergency care. I authorize the use of my mobile phone number and/or email address for appointment reminders, expiring insurance reminders, post-op instructions, reviews, surveys, in-office promotion, newsletters, and treatment plan follow-ups; however, I understand that notifications can be stopped by notifying a team member. 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)