DENTAL REGISTRATION AND HISTORY

Patient Information

Date________________Social Security #__________________________Birthdate____________________

Last Name________________________First Name_________________________Middle Initial________

Local Street Address____Apt/Suite #_________________

City__________________________________State_______________________Zip___________________

Home Phone __________________Cell________________E-mail______________________________

Employer______________________________ Work_________________________Ext_______________

How would you prefer to be contacted? ____

Sex: Male/Female Marital Status: Minor/Single/Married/Widowed/Divorced/Partnered/Separated

If seasonal, please provide Northern Address____

City_________________________State___________Zip_______Northern Phone__________________

Emergency Contact___________________Phone#__________________Relationship_______________

Whom may we thank for referring you____

Primary Insurance

Insurance Company Name___________________________________Phone________________________

Address____________________________City________________________State_____Zip__________

Insured Name_______________________Birthdate_______________Relationship_________________

Insured Social Security #_________________________Employer Name___________________________

Policy/ID #___________________________________Group #__________________________________

Assignment and Release:
I hereby authorize payment directly to ____________________________for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance, and all services rendered on my behalf or my dependents. I authorize the above doctor and or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature_______________________________________ Date____________________________________