

**PATIENT REGISTRATION**

Patient Name: \_\_\_\_\_  
Last First Middle Nickname

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Daytime contact #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Email address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Patient Age: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Status: Single  Married  Widowed  Divorced

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip

Who is responsible for this account? \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip

Business Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Extension or Department: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Method of Payment: Cash Check Debit Card Visa Master Card AMEX Discover

We offer 90 days same as cash for procedures over \$300

Ask for details at the front desk.

**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 to another dentist. I understand that I am responsible for all costs of dental treatment regardless of insurance coverage. I authorize release of any information relating to evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I attest to the accuracy of the information on this page.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please check all that apply:**

**I prefer to have my appointments confirmed by:**  voice  text  email