Patient Registration Form

Personal Information

Responsible Party ____
First Name Initial Last Name

Patient ____
First Name Initial Last Name

Address ____

City ____________________ State ______________ Zip ______________

Home Phone ______________ Work ______________ Cell ______________

Birthday____________________ Social Security ______________

Email Address ____________________ ☐ check if you would like to receive email reminders and promotions

Emergency Contact

Name ____________________________ Relation ______________

Phone number ______________ Phone number ______________

Employer Information of Subscriber Insurance

Employers Name ____________________ Phone number ______________

Address ____

City ____________________ State ______________ Zip ______________

Full time student Yes_____ No _______ Where ______________________________

Insurance Information (If you do not know the following information please contact your insurance company by phone or internet.)

Subscribers Name ______________ Social Security ______________ DOB __________

Insurance Company ____________________ Subscriber ID ______________

Phone number ______________ Address ______________________

City ____________________ State ______________ Zip ______________

Plan Name ____________________ Group Number ______________

Payor ID ____________________ Individual Deductible _$______________

Individual yearly max _$______________ Renewal date ____/___/_______

Secondary Insurance Information

Subscribers Name ______________ Social Security ______________ DOB __________

Insurance Company ____________________ Subscriber ID ______________

Phone Number ______________ Address ______________________

City ____________________ State ______________ Zip ______________

Plan Name ____________________ Group Number ______________

Payor ID ____________________ Individual Deductible _$______________

Individual yearly max _$______________ Renewal date ____/___/_______

Referral source

How did you hear about us? ____

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at the time of service**.

If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account, should collection procedures or small claims court become necessary, will be passed on to the patient and/or the responsible party.

I understand that, due to any false information, I will be subject to criminal prosecution

____________________ ____
Date Signature of patient (responsible party of minor)

We are preferred providers with the following companies: ***Aetna, Ameritas, Assurant/DHA, Blue Cross Blue Shield, Careington, Cigna, CNIC, Delta Dental, GEHA, Guardian, Humana, Medicaid, MetLife, Principal, United Concordia and United Healthcare.***