PATIENT NUMBER

PATIENT'S NAME _____
Last First Initial

DATE _____ DATE OF BIRTH _____

HOW DO YOU WISH TO BE ADDRESSED _____

SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE RESIDENCE _____ BUSINESS _____

PATIENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO WILL PAY THIS ACCOUNT _____

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT'S SOCIAL SECURITY NUMBER _____

SPOUSE'S SOCIAL SECURITY NUMBER _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

_____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

_____ _____
Date Name

I hereby authorize payment directly to the Dentist of the Group Insurance Benefits otherwise payable to me.

_____ _____
Date Name

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS _____

NAME OF INSURANCE CO _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NUMBER _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS _____

NAME OF INSURANCE CO _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NUMBER _____

Unless prior arrangements are made we request all balances be paid within 10 days of receipt of your statement. If this is not possible and we have not previously made other arrangements, please call us to do so. A thirty day old balance will have a 1.5 percent bookkeeping fee applied. This is an annual rate of 18 percent. We hope our policy is convenient to you, but if not, please feel free to discuss individual arrangements with us.

In the event of default, and my account is assigned to an attorney, I agree to pay all costs of collection including reasonable attorney fees.

Signature _____

E-mail _____

Cell # _____

ADULT REGISTRATION

MED ALERT