Patient Registration Form

Patient Name _____ Date of Birth _____

Responsible Party _____

Address _____City_____ State ____ Zip _____

Phone (home) _____(work) _____

Employer _____

Dental Insurance Information

Subscriber Name _____ S.S. # _____

Date of Birth _____

Insurance Carrier _____

Insurance Address _____

Insurance Telephone # _____

Group Name _____ Group # _____ Policy # _____

Does this plan cover family members? …… Yes No

Addition coverage? …….. Yes No

Additional Dental Insurance Coverage

Subscriber Name _____ S.S. # _____

Date of Birth _____

Insurance Carrier _____

Insurance Address _____

Insurance Telephone # _____

Employer _____

Group Name _____ Group # _____ Policy # _____

Does this plan cover family members? …… Yes No

Release of Information: I authorize the release of any dental information necessary to process this claim.

Signed _____ Date _____

(patient, or parent if minor)