PATIENT REGISTRATION

NAME (LAST, FIRST, MIDDLE (NICKNAME)) | DATE OF BIRTH | PRESENT AGE | S M D W C

ADDRESS | CITY | STATE/PROV. | ZIP/P.C.

HOME PHONE / CELL PHONE	FAMILY PHYSICIAN / MEDICAL ALERT
SS #/SIN / E-MAIL	NEAREST RELATIVE
EMPLOYER / OCCUPATION	PHONE
ADDRESS	ADDRESS
PERSON RESPONSIBLE FOR ACCOUNT	**CREDIT REFERENCES**
NAME / RELATIONSHIP	BANK
ADDRESS	CHECKING ACCOUNT NO.
SS #/SIN / E-MAIL	CREDIT CARD (S)
EMPLOYER / OCCUPATION	PREVIOUS EMPLOYER
ADDRESS	ADDRESS
INSURANCE INFORMATION	**INSURED DEPENDENT'S NAME**
INSURANCE COMPANY	SPOUSE / BIRTHDATE
NAME OF GROUP DENTAL PROGRAM	OTHER NAME
POLICY NUMBER / GROUP NUMBER	NAME
UNION LOCAL	RELATIONSHIP / BIRTHDATE
EFFECTIVE DATE OF INSURANCE / TIME LIMIT FOR CLAIMS	NAME
METHOD OF PAYMENT ☐ UCR ☐ SCHEDULE OF BENEFITS ☐ OTHER	RELATIONSHIP / BIRTHDATE
CO-INSURANCE: INSURANCE CO. SHARE / PATIENT'S SHARE	NAME
DEDUCTIBLE: ☐ YES ☐ NO $ _____ AMOUNT	RELATIONSHIP / BIRTHDATE
IF YES: ☐ INDIVIDUAL ☐ FAMILY ☐ ANNUAL ☐ LIFETIME	NAME
COVERAGE	RELATIONSHIP / BIRTHDATE
	SECONDARY COVERAGE
	NAME OF SUBSCRIBER
	SUBSCRIBER'S S.S. NUMBER
EXCLUSIONS ☐ PROPHYLAXIS ☐ ORTHODONTICS	NAME & ADDRESS OF EMPLOYER
☐ OTHER	
STANDARD FORM ACCEPTED? ☐ YES ☐ NO	DENTAL PLAN NAME
	UNION LOCAL/GROUP NUMBER
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	CARRIER NAME & ADDRESS

PATIENT REGISTRATION

PATIENT NAME _____