PATIENT REGISTRATION

Patient's Name _____ Birth Date _____

Name of Spouse _____ Birth Date _____

If a child, parent's name _____

Single ☐
Widowed ☐
Married ☐
Divorced ☐
Separated ☐

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ What is the best way to contact you? _____

Purpose of this Appointment _____

In Case of Emergency, Who Should Be Notified _____ Phone _____

Person Responsible for this Account _____ Financial Institution _____

Social Security # _____ Driver's License # _____

Spouse's Social Security # _____ Spouse's Driver's License # _____

If Using Charge Card, Name _____ Card No. _____ Exp. Date _____

Name of Insurance Company _____

Policy No. _____ Group No. _____

If Spouse has Insurance, Name of Insured _____

Name of Insurance Company _____

Policy No. _____ Group No. _____

Whom May We Thank for Referring You _____

Comments: _____

_____

_____

I acknowledge and agree that a service charge per month will be changed on all balances remaining unpaid after 90 days from the date said amounts are incurred. I understand that I am responsible for all costs of dental treatment.
In the event of default and referral to an attorney or collection agency. I agree to pay all costs of collection including reasonable attorneys' fees. I understand that the above information is given for the purpose of obtaining credit and I certify that, to the best of my knowledge, the above information is complete and accurate as of the date of this application.

Signature _____ Date _____