PATIENT REGISTRATION FORM

Today's Date _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name	Relationship to Patient	Marital Status S M D W
Street Address	Phone	
City	State	Zip
Employer	Years Employed	Soc. Sec. No.
Business Address	Phone	
PATIENT'S NAME	Birthdate	Sex M F
Address (if different from above)		Phone
City	State	Zip
Employer Business Address		Phone
Soc. Sec. No. Marital Status S M D W	Spouse's Employer	
Emergency Contact Name	Phone	Referred By

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name	Birthdate	Soc. Sec. No.
Employer	Business Address	
Insurance Co.	Group No.	
Patient's Relationship to Subscriber: Self Spouse Dependent	Dental Insurance Used This Benefit Year? Yes No	

SECONDARY INSURANCE (If Covered Under More Than One Dental Plan)

Subscriber's Name	Birthdate	Soc. Sec. No.
Employer	Business Address	
Insurance Co.	Group No.	
Patient's Relationship to Subscriber: Self Spouse Dependent	Dental Insurance Used This Benefit Year? Yes No	

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

It is the insured's responsibility to know their insurance coverage and pay their portion on the date of service. Any balance not paid by the insurance is to be paid by the responsible party within 90 days. Any unpaid balance is subject to a finance charge of 1.5% monthly/18% annually (unless other arrangements have been made).

Signature of Patient or Responsible Party _____ Date _____