PATIENT INFORMATION

(Person being seen for visit)

NAME _____
Last First Initial

HOW DO WISH TO BE ADDRESSED _____

CIRCLE: (Single Married Separated Divorced Widowed Minor) (Male Female)

SS# _____ Date of Birth _____ Age _____

RESIDENT - STREET _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ FAX _____

E-MAIL: _____

GUARANTOR INFORMATION

(Person responsible for account)

NAME _____
Last First Initial

HOW DO WISH TO BE ADDRESSED _____

CIRCLE: (Single Married Separated Divorced Widowed Minor) (Male Female)

SS# _____ Date of Birth _____ Age _____

RESIDENT - STREET _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ FAX _____

E-MAIL: _____

ARE THERE OTHER FAMILY MEMBERS YOU WOULD LIKE US TO SEE IN THE NEAR FUTURE? ❑ YES ❑ NO

IF YES, PLEASE TELL US THE MEMBERS OF YOUR FAMILY:

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

NAME _____ RELATIONSHIP _____ AGE _____

EMPLOYMENT INFORMATION FOR GUARANTOR

(Person responsible for account)

NAME OF EMPLOYER _____

ADDRESS - STREET _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ FAX _____

POSITION _____ HOW LONG HELD? _____

NAME OF SUPERVISOR _____ DRIVER'S LICENSE # _____

PLEASE TURN OVER TO COMPLETE REGISTRATION INFORMATION

REGISTRATION

REFERRAL INFORMATION

(Whom may we thank for this referral)

DOCTOR_____ ADDRESS _____

FRIEND_____ ADDRESS _____

DHCA PATIENT_____ OTHER_____

❑ YELLOW PAGES ❑ NEWSPAPER ❑ DIRECT MAIL ❑ BENEFITS MANAGER

MEDIA ADVERTISEMENT:

❑ PRINT ❑ RADIO ❑ TELEVISION ❑ INTERNET

❑ OTHER_____

FINANCIAL INFORMATION

HOW WILL YOU BE PAYING FOR YOUR TREATMENT? ❑ CASH ❑ CREDIT CARD ❑ INSURANCE/COPAYMENT

OTHER _____

EMERGENCY INFORMATION

(Someone to notify in case of an emergency and not living with you)

NAME _____

ADDRESS _____

PHONE - HOME_____ WORK _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be deemed necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
I understand that I am financially responsible for payments in full of all accounts.
By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care provider.
I attest to the accuracy of the information on the front and back of this form.
I authorize the dental group and/or its agents to transmit patient billing and/or insurance information to my personal and/or insurance carrier electronic communication address in lieu of U.S. Postal Service.

PATIENT OR GUARDIAN'S SIGNATURE_____ DATE _____