

Today's Date: _____



Dependent Registration Form

Please fill out this form completely. The better we communicate, the better we can care for you.

PATIENT

Patient's Legal Name: _____ Preferred Name: _____ Male Female
Last First

Birth date: ____/____/____ Age: ____ SS# ____ - ____ - ____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone(____) ____ - ____ Cell Phone(____) ____ - ____

Person Financially Responsible _____

Appointments should be confirmed by
 Text Cell Call Cell Call Home

NEW PATIENTS

Previous/Current Dentist: _____ Last Visit Date: _____

How did you hear about us? _____

Other Family Members Seen by Us: _____

FATHER

Legal Name: _____ Birth date: ____/____/____ SS# ____ - ____ - ____
Last First

Home Phone(____) ____ - ____ Cell Phone(____) ____ - ____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____

MOTHER

Legal Name: _____ Birth date: ____/____/____ SS# ____ - ____ - ____
Last First

Home Phone(____) ____ - ____ Cell Phone(____) ____ - ____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____

DENTAL INSURANCE (PRIMARY)

Insured's Name: _____ Relation: _____ Insured's DOB: ____/____/____

SS#: ____ - ____ - ____ Insured's Employer: _____

Insurancy Company: _____ ID: _____ Group# _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone # (____) ____ - ____

DENTAL INSURANCE (SECONDARY)

Insured's Name: _____ Relation: _____ Insured's DOB: ____/____/____

SS#: ____ - ____ - ____ Insured's Employer: _____

Insurancy Company: _____ ID: _____ Group# _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone # (____) ____ - ____

CONTACT IN CASE OF EMERGENCY

Name: _____ Relation: _____ Phone # (____) ____ - ____

The following persons are authorized to have access to billing, appointment, and treatment information (person responsible for account must be listed)

Name: _____ Relation _____ Name: _____ Relation _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I (or the minor patient) may need during diagnosis and treatment with my informed consent.

I understand I am responsible for payment of services at the time they are rendered. If this office participates with my insurance, I understand I am also responsible to pay any co-payment and deductible at the time service is rendered.

Patient Signature (or Guardian/Parent if under 18): _____ Date: _____