**PATIENT REGISTRATION**

(PLEASE PRINT)

Patient _____
Last Name First Name Middle Initial Preferred Name
*If child, parent's name _____

Home Phone _____ Cell Phone_____
Work Phone_____Email _____
Street Address _____City_____ State_____ Zip_____
Gender _____ Age _____ Birthdate _____
Employed by _____ Occupation _____
Business Phone _____
Spouse Name_____
Spouse Employed by _____ Occupation _____
Business Phone _____
Who is responsible for this account? _____Relationship to Patient _____
Social Security # _____
Dental Insurance Company _____Group # _____ID#_____
In case of emergency, who should be notified? _____ Phone _____
Whom may we thank for referring you? _____

**Authorization and Release**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to a third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent/ guardian if minor)

_____

Date