

ADULT PATIENT REGISTRATION

Name _____	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
Residence Address _____	City _____	State _____	Zip _____	Home Phone _____	
Social Security Number _____	Birthdate _____				
Employed By _____	City _____	State _____	Zip _____	Business Phone _____	
Occupation _____	How Long Held _____				
Nearest Realitive Not Living With You _____	City _____	State _____	Zip _____	Phone _____	

IF MARRIED, PLEASE COMPLETE THE FOLLOWING

Spouse Name _____	Social Security Number _____	Birthdate _____			
Address (If different than yours) _____	City _____	State _____	Zip _____	Home Phone _____	
Spouse Employed By _____	City _____	State _____	Zip _____	Business Phone _____	
Occupation _____	How Long Held _____				

Whom may we thank for referring you to us? _____

Relationship _____ Phone _____

Is any member of your immediate family a patient here? YES NO

If yes, Name: _____

Who will be financially responsible for this account _____

Account will be paid today by Cash Check Credit Card

IF YOU HAVE DENTAL INSURANCE PLEASE COMPLETE.

Name of Insured/Subscriber (Primary) _____	Insurance Company _____
Employer _____	Group Number _____
Name of Spouse's Dental Insurance Co. (Secondary) _____	Employer _____

We make every effort to keep down the cost of your dental care. You can help by paying for treatment at the time of your visit. Payment for services is due at time services are rendered unless financial arrangements are made with our business staff.

If you have dental insurance, remember that your insurance is a contract between you, your employer, and the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. The insurance co-payment, that portion of the fee which is payable by the patient, is due at the time of service.

Authorization and Release

I authorize the doctor to release any information including the diagnosis and the records on any treatment or examination rendered on my behalf during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my 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.

Signature of patient or parent if minor _____

Date _____