Patient Registration

Date _____ Patient's birthdate _____

Driver's License _____

Soc.Sec.# _____

Referred by _____

Patient's name _____ Resident & Cell Phone _____

Spouse's name _____ Birthdate _____ S.S.# _____

Street address _____ City _____ State _____ Zip _____

Employed _____ Occupation _____ Bus.phone _____

Employed (Spouse) _____ Occupation _____ Bus.phone _____

If patient is a minor give name of : Mother: _____ Father: _____

Employed (Mother) _____ Occupation _____ Bus.phone _____

S.S.# _____ Birthdate _____

Employed (Father) _____ Occupation _____ Bus.phone _____

S.S.# _____ Birthdate _____

If you were to become ill in our office please give name and phone number you would want called if we were unable to reach your spouse . Name _____ Phone _____

In order for our office staff to assist you courteously and efficiently, please indicate which method of payment you prefer:

_____ I will pay in full by cash or check

_____ I would like to pay by using _____ VISA _____ MASTERCARD OR _____ DISCOVER

_____ Please help to assist me with filing my insurance

_____ I would like to apply for Care Credit

I UNDERSTAND THAT ONLY THE ROOT CANAL TREATMENT WILL BE DONE IN THIS OFFICE. THE PERMANENT RESTORATION(SILVER FILLING,CROWN,ETC.) WILL BE DONE BY MY REGULAR DENTIST.

SIGNATURE _____

Parental permission for child _____

Name of Dental insurance _____

Insurance Personal ID# _____

I authorize release of any information necessary for insurance claim or if accident, I authorize release of information concerning accident or treatment. I understand I am responsible for payment regardless of insurance claim.

Patient's signature _____ Parental permission _____