

**CONFIDENTIAL PATIENT REGISTRATION**

Dr. \_\_\_\_\_

Welcome to our dental practice. Please complete the following important information.

**Contact Information**

Mr./Mrs./Ms/Miss/Dr. (please circle one)

Surname: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Preferred name: \_\_\_\_\_ Gender: Female \_\_\_ Male \_\_\_ Birthdate M/D/Y: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Preferred daytime contact number: (√) H\_\_\_ C\_\_\_ W\_\_\_ Email: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Responsible Party – re treatment and financial considerations** (Please complete all information if different from above)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Preferred daytime contact number: (√) H\_\_\_ C\_\_\_ W\_\_\_

Email: \_\_\_\_\_

If the patient is a minor and a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care: \_\_\_\_\_

**Insurance Information**

Policy holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Birthdate M/D/Y: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance company \_\_\_\_\_ Group/Policy #: \_\_\_\_\_ Certificate/Div/ID #: \_\_\_\_\_

Coverage: Basic: \_\_\_\_\_ % limit: \$ \_\_\_\_\_ Major: \_\_\_\_\_ % limit: \$ \_\_\_\_\_ Ortho: \_\_\_\_\_ % limit: \$ \_\_\_\_\_

**Secondary policy**

Policy holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Birthdate M/D/Y: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance company \_\_\_\_\_ Group/Policy #: \_\_\_\_\_ Certificate/Div/ID #: \_\_\_\_\_

Coverage: Basic: \_\_\_\_\_ % limit: \$ \_\_\_\_\_ Major: \_\_\_\_\_ % limit: \$ \_\_\_\_\_ Ortho: \_\_\_\_\_ % limit: \$ \_\_\_\_\_

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

\_\_\_\_\_  
Signature of patient or parent/guardian of minor\_\_\_\_\_  
Date