PATIENT REGISTRATION

NAME (LAST, FIRST, MIDDLE (NICKNAME)) | DATE OF BIRTH | PRESENT AGE | S M D W C

ADDRESS | CITY | STATE/PROV. | ZIP/P.C.

HOME PHONE | CELL PHONE

SS #/SIN | E-MAIL

EMPLOYER | OCCUPATION

ADDRESS

PERSON RESPONSIBLE FOR ACCOUNT

NAME | RELATIONSHIP

ADDRESS

SS #/SIN | E-MAIL

EMPLOYER | OCCUPATION

ADDRESS

INSURANCE INFORMATION

INSURANCE COMPANY

NAME OF GROUP DENTAL PROGRAM

POLICY NUMBER | GROUP NUMBER

UNION LOCAL

EFFECTIVE DATE OF INSURANCE | TIME LIMIT FOR CLAIMS

METHOD OF PAYMENT ☐ UCR ☐ SCHEDULE OF BENEFITS ☐ OTHER

CO-INSURANCE: INSURANCE CO. SHARE | PATIENT'S SHARE

DEDUCTIBLE: ☐ YES ☐ NO $_____ AMOUNT

IF YES: ☐ INDIVIDUAL ☐ FAMILY ☐ ANNUAL ☐ LIFETIME

COVERAGE

EXCLUSIONS ☐ PROPHYLAXIS ☐ ORTHODONTICS

☐ OTHER

STANDARD FORM ACCEPTED? ☐ YES ☐ NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

FAMILY PHYSICIAN | **MEDICAL ALERT**

NEAREST RELATIVE

PHONE

ADDRESS

CREDIT REFERENCES

BANK

CHECKING ACCOUNT NO.

CREDIT CARD (S)

PREVIOUS EMPLOYER

ADDRESS

INSURED DEPENDENT'S NAME

SPOUSE | BIRTHDATE

OTHER NAME

NAME

RELATIONSHIP | BIRTHDATE

NAME

RELATIONSHIP | BIRTHDATE

NAME

RELATIONSHIP | BIRTHDATE

NAME

RELATIONSHIP | BIRTHDATE

SECONDARY COVERAGE

NAME OF SUBSCRIBER

SUBSCRIBER'S S.S. NUMBER

NAME & ADDRESS OF EMPLOYER

DENTAL PLAN NAME

UNION LOCAL/GROUP NUMBER

CARRIER NAME & ADDRESS

PATIENT NAME _____

PATIENT REGISTRATION