DENTAL REGISTRATION FORM

PATIENT INFORMATION

Name:Last_____First_____Middle Initial_____Preferred Name_____
Social Security #_____Date of Birth_____Male☐ Female☐
☐Married☐Single☐Widowed☐Divorced☐Separated☐Minor Driver's License #_____State_____
Home Address_____
City_____State_____Zip_____Email_____
Occupation _____ Employer _____
Employer Address_____Employer Phone _____
Spouse's Name_____ Date of Birth _____Social Security #_____
Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Cell _____
Emergency Contact: Someone who does not live in your household: Name _____
Phone # _____ Relationship: _____

Responsible Party

Name:Last_____First _____ Middle Initial___ Relationship to Patient_____
Social Security #_____Date of Birth_____ Male☐ Female☐
Home Address _____
City _____ State _____ Zip _____ Relationship to Patient _____
Phone # _____ Cell # _____ Driver's License #_____ State_____
Employer_____ Employer Address _____

DENTAL INSURANCE

Primary Dental Insurance Coverage
Subscriber Name: Last_____ First _____ Relationship to Patient _____
Address_____
Social Security # _____Date of Birth_____ Male☐ Female☐
Employer _____ Employer Address _____
Insurance Plan_____ Subscriber's ID _____Group # _____

Secondary Dental Insurance Coverage
Subscriber Name: Last_____ First _____ Relationship to Patient _____
Address_____
Social Security # _____ Date of Birth_____ Male☐ Female☐
Employer _____ Employer Address _____
Insurance Plan_____ Subscriber's ID _____ Group # _____

Assignment and Release:
I hereby authorize release of any information needed and also authorize my insurance company to pay directly to Advanced Aesthetic Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and that it is my responsibility to inform this office of any changes in my insurance information/coverage. I authorize the use of my signature on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date _____
Signature of patient or parent/guardian of minor
Please note: Parent/guardian who signs for minor child is responsible for payment.

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

(OVER)