

Patient Registration (Please **PRINT** clearly & Sign at the bottom)

Patient Name _____ Male Female
Date of Birth _____ Social Security # _____
Address _____
City _____ State _____ Zip _____
Day Phone () _____ Evening Phone () _____
E-mail Address _____ @ _____

Dental Insurance

Claims Mailing Address _____
City _____ State _____ Zip _____
Phone () _____
Subscriber ID # _____ Group # _____
Subscriber Name (if different from patient) _____
Subscriber Date of Birth _____ Social Security # _____
Copy of Card Included Yes No

Medical Insurance

Claims Mailing Address _____
City _____ State _____ Zip _____
Phone () _____
Subscriber ID # _____ Group # _____
Subscriber Name (if different from patient) _____
Subscriber Date of Birth _____ Social Security # _____
Copy of Card Included Yes No

I authorize the use of this form on all my insurance submissions and the release of information to all my insurance company(s).
I authorize the dentist and/or his/her billing agency to act as my agent in helping me obtain payment from my insurance company(s).
I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill, not my insurance company(s).

I understand that eligibility for coverage by my insurance company cannot be determined at this time. I wish to receive medical/dental services from the dentist and/or his/her staff. ***If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.***

I acknowledge full financial responsibility for services rendered by the dentist and hereby authorize any insurance benefits for services furnished, be paid directly to the dentist. I agree to pay all reasonable attorney fees and costs in the event of default of payment of my charges. ***I consent to diagnosis/treatment by the dentist and/or his/her staff.***

X _____ **Date**
Signature of Patient

X _____ **Date**
Signature of Parent (or Legal Guardian) and/or Person Responsible for Insurance (if different from patient)