PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION

Name _____ Birth date _____ Sex _____ M _____ F

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Cell (_____) _____ Social Security _____

_____ Minor _____ Single _____ Married _____ Divorced _____ Widowed _____ Separated

FOR CHILD OR TEEN

Nickname (if any) _____ School _____ Grade _____

Father's Full Name _____ Employer _____ Work Phone (_____) _____

Mother's Full Name _____ Employer _____ Work Phone (_____) _____

Other Children in Family
Name and Age _____

FOR ADULT

Employer _____ Position _____ Work Phone _____

Spouse's Name _____

Spouse's Employer _____ Position _____ Work Phone _____

Whom May We Thank for Referring you? _____

Person to Contact in Case of Emergency _____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Social Security # _____ Relationship to Patient _____

Address _____ Home Phone (_____) _____

Birth date _____ Employer _____ Work Phone (_____) _____

Insurance Company _____ Group # _____

SECONDARY INSURANCE

Name of Insured_____ Relationship to Patient _____

Birth date_____ Social Security # _____

Employer_____ Work Phone (_____) _____

Insurance Company_____ Group #_____

Please Initial and Sign Below

____ I hereby authorize the administration of such medications and performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care.

____ I assign all insurance benefits directly to **Dillon Dental Care, P.A.** I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions whether manual or electronic.

____ I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges.

Date Signature (parent or guardian if a minor)

Dillon Dental Care
09/04

REORDER # 0213305