CONFIDENTIAL REGISTRATION

Patient Name _____ **Birthday** _____ **SSN#** _____

Address _____ **City, State,Zip** _____

Employer _____ **Work#** _____ **Home#** _____ **Cell#** _____

DENTAL INSURANCE INFORMATION

Insured Person _____ **Birthday** _____ **SSN#** _____

Relationship to Patient _____ **ID#** _____

Insurance Company _____ **Group #** _____
Address _____ **City, State,zip** _____

Secondary Dental Insurance

Insured Person _____ **Birthday** _____ **SSN#** _____

Relationship to Patient _____ **ID#** _____

Insurance Company _____ **Group#** _____

Address _____ **City, State,Zip** _____

HOW WERE YOU REFERRED TO THIS OFFICE?: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payor and or other health practitioners.
I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE OF PATIENT, PARENT IF MINOR: _____

Payment In Full Is Due at The Time of Visit

For your convenience, we offer the following methods of payment:
CASH, CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS HEALTHCARE CREDIT LINE and CAPITAL ONE HEALTHCARE FINANCE.