

PATIENT REGISTRATION

Thank you for filling out this form completely. It will enable us to help you more effectively.

PATIENT INFORMATION

NAME: _____
Mr Mrs Ms Dr Last First Middle

I prefer to be called: _____ Male Female

_____/_____/_____
Birthdate Age Social Security Number

Single Married Divorced Widowed Separated

Street Address: _____

Mailing Address: _____

City State Zip

Home # _____ Work # _____ Ext: _____

Cell # _____ Email _____

EMPLOYER: _____

Address: _____

City State Zip

Occupation: _____ How long there? _____

OTHER INFORMATION:

Guarantor (person responsible for paying account): _____

Relationship of patient to guarantor: _____

Who may we thank for referring you? _____

Where and when are the best times to reach you: _____

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Self Spouse Other: _____

Birthdate: ____/____/____ SS #: _____-____-____

Insured's Employer: _____

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SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

City State Zip

Insurance Co. Phone #: (_____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Self Spouse Other: _____

Birthdate: ____/____/____ SS #: _____-____-____

Insured's Employer: _____

SPOUSE INFORMATION

NAME: _____
Mr Mrs Ms Dr Last First Middle

Birthdate: ____/____/____ SS #: _____-____-____

Work # _____ Ext: _____

EMPLOYER: _____

Address: _____

City State Zip

Occupation: _____ How long there? _____

PARENT INFORMATION (for minors)

NAME: _____
Mr Mrs Ms Dr Last First Middle

Birthdate: ____/____/____ SS #: _____-____-____

Cell # _____ Work # _____ Ext: _____

EMPLOYER: _____

Address: _____

City State Zip

Occupation: _____ How long there? _____

In the event of an emergency, is there

someone who lives near you that we should contact?

Name: _____ Relationship: _____

Home # _____ Work # _____ Ext: _____

OFFICE POLICIES:

All treatment is expected to be paid in full before or at the time of service. If you have insurance, once eligibility has been confirmed, we will take an assignment of benefits on most insurance plans. CaringDentalCenter will assist you with the initial claim for dental services. Payment of patient's co-pay is expected at time of treatment. If you need a payment plan to help with your cost of treatment, it is expected that this be set up before treatment begins.

By signing I authorize:

- All insurance checks to be paid directly to CaringDentalCenter
- Credit checks and assistance in setting up financial arrangements
- Release of records to specialists or insurance companies as needed

In addition, my signature is an agreement to:

- Endorse and forward insurance checks to CaringDentalCenter
- Pay costs for collection of unpaid debt
- Pay a \$30 charge for checks returned for any reason
- Pay a 12% finance charge and late fee on balances after 30 days

_____/____/____
Patient/Parent/Guardian Signature