REGISTRATION

Welcome and thank you for selecting us as your dental health care professionals!

PATIENT INFORMATION

Name_____ Date _____

Parent's name (IF MINOR) _____

Address street_____city_____zip code_____

Birthdate _____ Age _____ Gender _____ SS# _____

Home phone _____ Email _____ May we call you at work? Y N

Employer _____ Cell phone _____

Occupation _____ Work Phone _____

How did you find out about us? _____

IN AN EMERGENCY, who should we notify? _____ Phone _____

DENTAL INSURANCE INFORMATION

Name of person responsible for account _____

Relationship to patient _____ Birth date _____ Social Sec # _____

Address _____

Person responsible employed by _____

Business address _____

Business phone _____

Insurance company _____

Insurance company address _____

Insurance company phone _____

Name of dental plan _____

Group # _____

Is patient covered by additional dental insurance? Y N (If yes, list on back)

RELEASE:

*I give permission for my dentist and his clinical team to take any necessary x-rays, photos, or study models to enable complete diagnosis and treatment.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
*I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.
*I assign dental benefit payments to be paid directly to Springs Dental Care, P.C. from my insurance company.
****I understand that my insurance is an agreement between me and my insurance company. I also understand that I am responsible for my balance regardless of my insurance.***
*I understand that I may be charged a 1.5% per month finance charge if my balance goes beyond 30 days.

PATIENT'S OR GUARDIAN'S SIGNATURE _____DATE_____