If you do not have dental insurance complete *only* the release section below.

DENTAL INSURANCE INFORMATION

For routine claims, we will provide you with a completed superbill of services rendered, for you to attach to your insurance form. As a courtesy for complex treatment estimates, we will complete and send an insurance form for predetermination of your benefits. Your careful answers will expedite processing by your insurance company.

YOUR PRIMARY CARRIER

POLICY OWNER INFORMATION

Policy owner name _____ Social security number _____

Relationship of patient to policy owner _____

Employer _____ Insurance company _____

Policy number _____ Group number _____

YOUR SECONDARY CARRIER

POLICY OWNER INFORMATION

Policy owner name _____ Social security number _____

Relationship of patient to policy owner _____

Employer _____ Insurance company _____

Policy number _____ Group number _____

RELEASE

- I authorize the dentist to perform diagnostic procedures including taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation.
- I authorize the release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I understand that I am responsible for **all** costs of dental treatment.
- I attest to the accuracy of the information on this form.

Patient's or Responsible Party's signature	Date	Dentist's signature	Date

Welcome! So we may provide you with the best possible service, please complete both sides of this page. Of course, all information is confidential.

GENERAL VISIT INFORMATION

What is the reason for your visit? _____

Is your visit in this office a result of:

A problem resulting from an occupational illness / injury? . . . . . **YES NO**

A problem resulting from an automobile or other accident? . . . . . **YES NO**

GENERAL PATIENT INFORMATION

Please complete the general information section for yourself. If you are completing this form for a child or dependent *also* complete the dependent section below.

Name _____ Birth date _____

How do you wish to be addressed? _____

Residence address _____ Residence phone _____
Number Street City State Zip

Employer _____ Occupation _____

Business address _____ Business phone _____
Number Street City State Zip

Social security number _____ Drivers license number _____

Marital status _____ Spouse's name _____

Person responsible for the account _____ Bank reference _____
Name / Branch City

DEPENDENT'S INFORMATION

Child's or dependent's name _____ Birth date _____

How should we address your child or dependent? _____ School _____ Grade _____

Dependent's address (If different from above) _____
Number Street City State Zip

Residence phone (If different from above) _____

Who is legally responsible? _____ Relationship _____ Phone _____

Residence address (If different from above) _____
Number Street City State Zip

ADDITIONAL INFORMATION

Please list any other family members who are patients in our practice _____

Whom may we thank for referring you to our practice? _____

In case of an emergency, who should we contact? _____ Phone _____

(Please continue on reverse side)

REGISTRATION QUESTIONNAIRE