Martin Family Dental Patient Registration

Patient Name: ____ Preferred Name: _______________

Birth Date: _____/______/_________ Gender: ____________ Social Security # :___________________________

Email: ____

Address: _________________________________ City: ____________________ State: ____ Zip: ______

Home Phone: _________________________________

Cell Phone: __________________________________

Alternate Phone: _______________________________

Account Holder (if patient under 18 years old)

Name: _____________________________________

Relationship to Patient: ___________________________

Birth Date: _____/______/_________ Gender: ____________

Social Security # :_____________________________

Address: ___________________________________

City: _____________________ State:____ Zip: ________

Home Phone: _________________________________

Cell Phone: __________________________________

Alternate Phone: _______________________________

Other Family Members in Our Practice: ________________

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How did you hear about us/whom may we thank for the referral? ______________________________

Emergency Contact: ____________________________

Relationship: _________________________________

Phone#: _____________________________________

Primary Dental Insurance
Subscriber Name:
Subscriber DOB & SSN:
Employer:
Insurance Company:
Member/Policy #:
Group/Plan #:
Phone Number:

Secondary Dental Insurance
Subscriber Name:
Subscriber DOB & SSN:
Employer:
Insurance Company:
Member/Policy #:
Group/Plan #:
Phone Number:

Medical Insurance
Subscriber Name:
Subscriber DOB & SSN:
Employer:
Insurance Company:
Member/Policy #:
Group/Plan #:
Phone Number:

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize 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 authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist
I understand that I am responsible for all costs of dental treatment.
I hereby authorize payment of insurance benefits directly to the dental or dental group, otherwise payable to me.
I attest to accuracy of the information provided on this page.

Signature: ____ Date: _______________