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: _____

_____

_____

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.

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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: _____