modern family DENTISTRY

we love your smile!

Patient Registration

Name_____
LAST FIRST MIDDLE PREFERRED

DOB_____ SS#_____ Gender: [ ]M [ ]F Married: [ ]Y [ ]N

Cell Phone_____ Home Phone_____ Work Phone_____

E-Mail _____

Preferred Method of Contact

- General Inquiry [ ]Cell [ ]Home [ ]Work
- Appointment Conformation [ ]Cell [ ]Home [ ]Work [ ]E-Mail
- 6 Month Recall [ ]Cell [ ]Home [ ]Work [ ]E-Mail

Address_____

City_____ State_____ Zip_____

How did you hear about us?_____

If someone referred you, please write down their name so we can thank them.

Who is responsible for the financial portion of this account?_____

Insurance Policy 1

Your relationship to the Subscriber: [ ]Self [ ]Spouse [ ]Child Subscriber's DOB_____

Subscriber Name_____ SS#_____

Subscriber's Address _____

Insurance Company_____ Phone #_____

ID#_____ Group #_____

Employer_____ Phone #_____

Insurance Policy 2

Your relationship to the Subscriber: [ ]Self [ ]Spouse [ ]Child Subscriber's DOB_____

Subscriber Name_____ SS#_____

Subscriber's Address _____

Insurance Company_____ Phone #_____

ID#_____ Group #_____

Employer_____ Phone #_____

Consent: The undersigned here by authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Doctor to make a thorough diagnosis. We respect and value your time as much as we do our own. If unable to keep your appointment kindly give 24 hours notice. There is a $25.00 charge for missed appointments. Your signature verifies all above information is correct to the best of your knowledge and that you are responsible for all bills incurred within this office. If you have dental insurance, your insurance may cover a portion of the treatment costs but you are responsible for the remaining balance.

Sign Name _____ Date _____