Patient Registration Form

Patient's Name:______________________________
Last First Middle

Address:______________________________
Street City/State Zip

Home Phone:__________ **Cell Phone:**__________ **Work Phone:**__________

Social Security #:__________ **Birth date:**________ **Email:**__________

Employer & Occupation:__________ **Location:**__________

I am best reached at my: Home Phone □ Cell Phone □ Work Phone □ Email □

How were you referred to Dentistry Unlimited? □ **Patient – please name:**__________

□ **Doctor – please name:**__________ □ **Employee- please name:** __________

□ **Insurance plan:** __________ □ **Commercial** □ **Yellow Pages** □ **On Line**

□ **Welcome Letter** □ **Walk In** □ **Newspaper** □ **Other:**__________

Dental Insurance Information

Primary Insured's Name:__________ **Social Security #:** __________

Insurance Company:__________ **Phone No:** __________ **Local No:** __________

Insurance Company Address:__________

Do you have double coverage? Yes □ No □ If yes, complete the following:

Secondary Insured's Name:__________ **Social Security #:**__________

Insurance Company: __________ **Phone No:** __________ **Local No:** __________

Insurance Company Address:__________

Emergency Information

Name of Emergency Contact Person:__________
Last First Middle

Primary Phone #: (______)__________ **Secondary Phone #:** (___)__________

I understand that fees for treatment rendered are due at the completion of each appointment unless prior arrangements have been made. If arrangements are made in advance, accounts may be budgeted. A charge of 1.25% and/or a $5.00 billing charge may be added to each account if payment is not received at the time of service. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am the responsible party for this dental account. I agree to grant the doctor permission to perform services that are necessary after consultation.

Signed:______________________________ **Date:**__________