Patient Registration Form

Dentistry Unlimited
Your smile deserves it.

Patient's Name:_____ **Birth Date:**_____
Last First Middle

If college student: Full Time: □ Part Time: □ Name of School:_____

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 □ Preschool visit □ Other:_____

Responsible Party Information

Parent / Responsible Party's Name:_____
Last First Middle

Address:_____
Street City/State Zip

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Birth Date:_____ **Social Security #:** _____ **Email:**_____

Employer & Occupation:_____ **Location:** _____

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 #: (_____)** _____

Relationship to Patient:_____

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 agree to grant the doctor permission to perform services that are necessary after consultation.

Signed:_____ **Date:**_____