PATIENT'S
NAME _____ Date of Birth _____ ❒Male ❒Female
Last First Initial

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH
TO BE ADDRESSED _____

Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Minor ❒

RESIDENCE – STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE STATE/NO. _____

EMAIL ADDRESS_____

☐ **YES**, send me (our family) reminders for upcoming appointments.

METHOD OF PAYMENT: Insurance ❒ Credit Card ❒ Cash ❒

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL _____

_____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF
EMERGENCY NOT LIVING WITH YOU _____

_____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

GROUP NO. #_____

SUBSCRIBER ID #_____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

GROUP NO. #_____

SUBSCRIBER ID #_____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I understand dental visits that require a two-hour-plus block (or longer) will require a deposit of 25% of the total amount of treatment indicated at the time the appointment is set and scheduled.

I authorize release of any information concerning my (or my child's) health care, advice 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 hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I understand that a 24-hour notice is required for appointment cancellation. I understand that Failed To Keep Appointment will be charged a fee.

I attest to the accuracy of the information on this page.

From time to time our practice sends out newsletters via e-mail to our patients with important health news, special offers, and surveys from our practice. Please check the appropriate box:

☐ **Yes**, I would like to receive Aspen Ridge Dental's monthly newsletter.

☐ **No**, I do not want to receive Aspen Ridge Dental's monthly newsletter.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION