Fairview Park Dental Care

PATIENT REGISTRATION

Date: ___________________ Email _______________________________________

Patient ____

(Last Name) (First Name) (Initial) (Preferred Name)

Male
Female   Married   Single   Divorced   Widowed

Age __________ Birthday _________/________/____________ Social Security# ______________-________-______________

Street Address ___________________________________ City __________________ State _________ Zip ________________

Telephone (Cell) ___________________________ (Work) _________________________ (Home) _______________________

Who may we thank for referring you? ____

How did you hear about our practice? ____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder's Name: ______________________________	Policy Holder's Name: ______________________________
Policy Holder's SS# ________________________________	Policy Holder's SS# ________________________________
Policy Holder's DOB _______________________________	Policy Holder's DOB: _______________________________
Subscriber ID: ____________________________________	Subscriber ID: _____________________________________
Relationship to Subscriber: ___________________________	Relationship to Subscriber: ___________________________
Employer Name: ___________________________________	Employer Name: ___________________________________
Employer Phone: ___________________________________	Employer Phone: ___________________________________
Insurance Company: ______________________________	Insurance Company: ______________________________
Insurance Group: ___________________________________	Insurance Group: ___________________________________
Insurance Phone: ___________________________________	Insurance Phone: ___________________________________

RESPONSIBLE PARTY *(If patient is under 18)*

Last Name _____________________________________ First _____________________________________ Initial__________

Address (If different) ____ State ____________ Zip __________________

Telephone (Cell) __________________________ (Work) ________________________ (Home) _________________________

Relationship to patient ____

EMERGENCY CONTACT

Last Name _____________________________________ First ______________________________________ Initial _________

Telephone (Cell) __________________________ (Work) __________________________ (Home) _______________________

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

Signature ____ Date ____