CREEKSIDE DENTAL

REGISTRATION FORM

Please Print

Today's date_____

PATIENT INFORMATION

Patient's Last Name:_____First:_____Middle:_____

Home Phone #:_____Work #:_____Cell #:_____Email Address:_____

Street Address:_____City:_____State:_____Zip Code:_____

Marital Status: Single ☐ Mar ☐ Sep ☐ Widow ☐ Gender: Male ☐ Female ☐ Birth Date:_____Age:_____

Occupation:_____Employer:_____Social Security No:_____

Person Responsible for Account:_____Address:_____Home Phone #:_____

Birthdate:_____Social Security #:_____Drivers License #:_____Cell Phone #:_____

REFERRED BY: ☐ Phone Book ☐ Location ☐ Patient (Name):_____☐ Other:_____

Person to Contact for Emergency:_____Phone No:_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is This Patient Covered By Insurance? ☐ Yes ☐ No Do You Have Medicaid? ☐ Yes ☐ No

Name of Primary Insurance:_____Group No:_____Policy No:_____

Subscriber's Name:_____Subscriber's SS No:_____Birthdate:_____

Patient's Relationship To Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance (if applicable) Subscriber's Name:_____Group No:_____Policy No:_____

Subscriber's Name:_____Subscriber's SS No:_____Birthdate:_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above named patient. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I authorize my insurance benefits to be paid directly to the dental office. I also authorize the dental office or insurance company to release any information required for this claim. I understand that I am responsible for any fees not paid by insurance and that a credit report may be obtained if necessary. I understand that if I need to change an appointment time, a 24-hour notification is necessary.

Signature_____Relationship to Patient_____Date_____

Patient, Parent or Guardian