REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ SEX _____M _____F S.S. NUMBER _____

HOME PHONE NUMBER_____ CELL PHONE NUMBER _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Mailing address if different than above: _____

E-MAIL ADDRESS:_____

EMPLOYER _____ WORK PHONE _____

IF MARRIED, WHAT IS YOUR SPOUSE'S NAME? _____

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S S.S. NUMBER _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK NUMBER _____

ARE YOU EXPERIENCING ANY DENTAL PROBLEMS AT THIS TIME? IF SO, WHAT? _____

_____

HOW LONG HAS IT BEEN SINCE YOU HAVE SEEN A DENTIST? _____

WHAT WAS DONE THEN? _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE DENTAL INSURANCE? _____

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

GROUP #: _____ SUBSCRIBER #:_____ PHONE #: _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # OF SUBSCRIBER: _____

I HEREBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES FOR MYSELF BY THE STAFF OF Tri-Town Family Dental.

I ALSO GIVE MY CONSENT TO ANY ADVISABLE AND NECESSARY DENTAL PROCEDURES, MEDICATIONS, OR ANESTHETICS TO BE ADMINISTERED BY OUR STAFF FOR DIAGNOSTIC PURPOSES OR DENTAL TREATMENT.

I UNDERSTAND AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES RENDERED, REGARDLESS OF INSURANCE COVERAGE.

_____ _____

(SIGNATURE) **(DATE)**