Welcome

Patient's Name _____
Last First Initial

Age: _____ Date of Birth _____

Male _____ Female _____ Age: _____

If Child: (Parent's Names) : Mother _____ D.O.B._____

Father :_____ D.O.B._____

Name preference: _____

Single __ Married _____ Separated____ Divorced_____ Widowed___

Residence: Street_____ P.O. Box _____

City _____ State _____ Zip _____

Telephone number: _____ Cell number: _____

Email address: _____

EMPLOYMENT

Patient Employer: _____,

Phone number: _____ Address: _____

If minor:

Parent Employer: _____ ***mother***

Phone number: _____ Address_____

Parent Employer: _____ ***Father***

Phone number: _____ Address_____

Drivers License No. (***patient***) _____

If Minor: Drivers License No. (***Mother***): _____

Drivers License No. (***Father***): _____

Patient Social Security number: _____

If minor:

Mother's SS number: _____

Father's SS number: _____

EMERGENCY CONTACT: not living with you

Name_____

Address: _____

Phone number: _____

DENTAL INSURANCE PRIMARY COVERAGE

Employee Name: _____ D.O.B._____

Employer Name: _____ Phone #: _____

Insurance Co. _____ Effective date: _____

Address: _____

Phone number: _____

Group number: _____

SS # number: _____ Member ID:_____

DENTAL INSURANCE SECONDARY COVERAGE

Employee Name: _____ D.O.B._____

Employer Name: _____ Phone #: _____

Insurance Co. _____ Effective date: _____

Address: _____

Phone number: _____

Group number: _____

SS # number: _____ Member ID:_____

CONSENT:

I consent to the diagnostic procedures and treatment by Black Creek Dental necessary for proper dental care.

I consent to Black Creek Dental's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records).

My consent to disclosure of records shall be effective until I revoke it in writing.

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

Patient and / or Guardian signature: _____

Date: _____

REGISTRATION