Registration Information Date_____

Please provide the following information so that we may best serve you. It is important to answer all questions completely. All information is confidential.

Name_____ Email_____

Home Address_____City_____Zip_____

Home Phone_____Cell Phone_____

Date of Birth_____Social Security No._____

Employer_____Work Phone_____

Person responsible for account balance_____

Dental Insurance Coverage_____

Subscriber S.S. No._____Subscriber D/O/B_____

Marital Status_____If married, name of spouse_____

Employer of spouse_____Work phone_____

In case of emergency who should be notified?_____

Relationship to you_____Phone_____

Physician's Name_____

Address_____Phone_____

Are you having discomfort or pain?_____Are you aware of any problems?_____

If so, nature of problem_____

How long has it been since you last visited a dental office?_____

Whom may we thank for referring you?_____

PAYMENT POLICY: We accept the following types of payment. Please indicate the type you will be using. Balances are due in full at the time of treatment. All balances not paid within 30 days are subject to a service fee of 1.6% per month.

Cash_____ Credit Card_____ Check_____ Care Credit_____

Signature_____