

# 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\_\_\_\_\_

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\_\_\_\_\_ Citibank financing\_\_\_\_\_

Signature\_\_\_\_\_