Dental South

Patient Registration/Agreement

Patient Name ______________________________

If a child, parent's name ______________________________

Address ______________________________

City ______________ **State** ________ **Zip Code** ______________

Telephone: Residence #______________ **Cell #** ______________

Birthdate______________**Email**______________

Social Security # (needed for insurance purposes only)______________

Driver's License # ______________________________

Patient/Parent's Employer ______________ **Work #**__________**ext**______

Referred by: ______________________________

In case of emergency, who should be notified? ______________________________

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Phone number of that person(s) ______________________________

Person responsible for account ______________________________

Spouse's Name ______________ **Spouse's SS#**______________

Spouse's Employer ______________________________

INSURANCE	Primary	Secondary
Name of dental plan	1)______________	2)______________
Name of policy holder	1)______________	2)______________
Social Sec or ID#	1)______________	2)______________
Group #	1)______________	2)______________

I understand that account balances over 30 days will be subject to a service charge, and I agree to assume responsibility for collection costs that may result from this account.

Patient/Parent
Signature______________________________**Date**______________

Office use only: _______ _______
DL **Staff**

5/09