CONFIDENTIAL PATIENT REGISTRATION

Welcome to Town Centre Dental Clinic. Please complete the following important information.

Contact Information

Mr. /Mrs./Ms/Miss/Dr. (please circle one)

Surname: _____ **First Name:** _____ **Middle Initial:** _____

Preferred Name: _____ **Gender:** Female____ Male ____ **Birthdate** M/D/Y: _____

Occupation: _____ **How Did you hear about us?**_____

_____

Address:_____ **Postal Code:**_____

Home Phone: _____**Cell Phone:** _____**Work Phone:** _____

Preferred Contact Number: (H)___ (C) ___ (W) ___ **Email:** _____

Emergency Contact: _____ **Relationship to Patient:** _____

Daytime Phone: _____ **Cell Phone:** _____

Responsible Party- re-treatment and financial considerations (Please complete all information if different from above)

Name: _____ **Relationship to patient:** _____

Address: _____ **Postal Code:** _____

Home Phone: _____**Cell Phone:** _____**Work Phone:** _____

Preferred Contact Number: (H)___ (C) ___ (W) ___ **Email:** _____

If the patient is a minor and a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care: _____

_____

Insurance Information

Policy Holder: _____**Relationship to patient:** _____ **Birthdate** M/D/Y:_____

Employer: _____ **Work Phone:** _____ **Email:** _____

Address:_____ **Postal Code**: _____

Insurance Company: _____ **Group/Policy #:** _____**Certificate/Div/ID #:** _____

Coverage: Basic: _____ **% limit: $** _____ **Major:** _____ **% limit: $** _____ **Ortho:** _____ **% limit: $** _____

Secondary Policy:

Policy Holder: _____**Relationship to patient:** _____ **Birthdate** M/D/Y:_____

Employer: _____ **Work Phone:** _____ **Email:** _____

Address:_____ **Postal Code:** _____

Insurance Company: _____ **Group/Policy #:** _____**Certificate/Div/ID #:** _____

Coverage: Basic: _____ **% limit: $** _____ **Major:** _____ **% limit: $** _____ **Ortho:** _____ **% limit: $** _____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

_____ _____

Signature of patient or parent/guardian of minor **Date**