

# SPRING LAKE DENTAL CARE

## PATIENT REGISTRATION

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Thank you for choosing our dental practice to help you maintain your oral health. In order for our staff to provide you with the best possible oral health treatment, we ask you to complete the following form.

The personal data will assist us in the administration of your account, for example dental insurance.

The medical information is needed for an accurate diagnosis of your overall condition and helps identify any precautionary measures needed to protect your health.

The information you provide will be kept strictly confidential.

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### PERSONAL DATA

NAME \_\_\_\_\_ DATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE NUMBERS: HOME \_\_\_\_\_ WORK \_\_\_\_\_

CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

NAME AND ADDRESS OF PERSON RESPONSIBLE FOR PAYING \_\_\_\_\_

OCCUPATION /PLACE OF EMPLOYMENT \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ NAME OF SPOUSE \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE? \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

OCCUPATION/PLACE OF EMPLOYMENT \_\_\_\_\_

GROUP OR POLICY NUMBER \_\_\_\_\_

DOES YOUR SPOUSE/PARENT HAVE DENTAL INSURANCE? \_\_\_\_\_

NAME OF INSURANCE COMPANY \_\_\_\_\_

OCCUPATION/PLACE OF EMPLOYMENT \_\_\_\_\_

GROUP OR POLICY NUMBER \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

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### AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professional, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits and discussing treatment needs.

\_\_\_\_\_  
Patient or Authorized Guardian's Signature

\_\_\_\_\_  
Date

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