PATIENT NUMBER

© 1994 Wisconsin Dental Association
(800) 243-4675

PATIENT'S NAME ______ Last ______ First ______ Initial

Date ______ Date of Birth ______ ☐ Male ☐ Female

IF CHILD: PARENT'S NAME ______ Last ______ First ______ Initial

HOW DO YOU WISH TO BE ADDRESSED ______

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

RESIDENCE - STREET ______

CITY ______ STATE ______ ZIP ______

BUSINESS ADDRESS ______

TELEPHONE: RES. ______ BUS. ______

PATIENT/PARENT EMPLOYED BY ______

PRESENT POSITION ______ HOW LONG HELD ______

SPOUSE/PARENT NAME ______

SPOUSE EMPLOYED BY ______

PRESENT POSITION ______ HOW LONG HELD ______

WHO IS RESPONSIBLE FOR THIS ACCOUNT ______

DRIVERS LICENSE NO. ______

METHOD OF PAYMENT: Insurance ☐ Credit Card ☐ Cash ☐

PURPOSE OF CALL ______

OTHER FAMILY MEMBERS IN THIS PRACTICE ______

WHOM MAY WE THANK FOR THIS REFERRAL ______

PATIENT/PARENT SOCIAL SECURITY NO. ______

SPOUSE/PARENT SOCIAL SECURITY NO. ______

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU ______

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME ______

EMPLOYEE DATE OF BIRTH ______

EMPLOYER ______ # YRS. ______

NAME OF INSURANCE CO. ______

ADDRESS ______

TELEPHONE ______

PROGRAM OR POLICY # ______

UNION LOCAL OR GROUP ______

SOCIAL SECURITY NO. ______

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME ______

EMPLOYEE DATE OF BIRTH ______

EMPLOYER ______ # YRS. ______

NAME OF INSURANCE CO. ______

ADDRESS ______

TELEPHONE ______

PROGRAM OR POLICY # ______

UNION LOCAL OR GROUP ______

SOCIAL SECURITY NO. ______

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

I understand accounts over 60 days will be assessed a service charge of 1.5% per month.

A charge will be made for broken appointments without 24 hour notice.

PATIENT'S OR GUARDIAN'S SIGNATURE ______ DATE ______

Form No. 110R

REGISTRATION