**Account Registration**

**Primary Account Holder: Secondary Account Holder:**

|  |  |
| --- | --- |
| **NAME** | **NAME** |
| Address | Address |
| City, State | City, State |
| Zip Code | Zip Code |
| Home phone | Home phone |
| Cell phone | Cell phone |
| Work phone | Work phone |
| E mail | E mail |
| Birth date  | Birth date  |
| Social Security Number | Social Security Number |
| Emergency Contact (name-phone-relationship) | Emergency Contact (name-phone-relationship) |
| **DENTAL INSURANCE** | **DENTAL INSURANCE** |

Please notify us if there are ever changes to your insurance. We will work with you to ensure that you receive the maximum benefits to which you are entitled. Please remember that the contract itemizing dental benefits is between you and your insurance carrier. If your dental plan does not pay within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental insurance carrier.

**I AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF** **EXAMINATION AND/OR TREATMENT.
I PERMIT PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DENTIST FOR HIS/HER SERVICES RENDERED.
I ACKNOWLEDGE AND ACCEPT RESPONSIBILITY FOR SERVICES NOT COVERED BY INSURANCE BENEFITS.**

PRIMARY ACCOUNT HOLDER SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_

SECONDARY ACCOUNT HOLDER SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **\*\*\*NEW PATIENTS ONLY\*\*\*** Whom may we thank for this referral? \_\_\_ Another Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_ Insurance Company \_\_\_ Website \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |