CEDAR ISLAND DENTAL REGISTRATION

Patient Information:

Patient's Name: _____ Preferred Name: _____ Date: ___/___/_____

Birth date: ___/___/_____ Sex: M ☐ F ☐ If Child: Parent's Name: _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Minor ☐ If child, do you have legal custody? Yes ☐ No ☐

Street Address: _____ City: _____ State: ____ Zip: _____

Phone/Home: _____ Work: _____ Cell: _____

Email: _____ Whom may we thank for this referral? _____

Who is responsible for this account? _____

Whom should we contact in case of emergency? _____ Phone: _____

Name of Spouse (if applicable): _____ Phone/Work: _____ Cell: _____

Primary Dental Insurance Information: Employee/Insured's Name: _____

Insured's Birth date: ___/___/_____ Relationship to patient: _____

Insurance Company Name: _____ Group Number: _____

Address: _____

Phone: _____

Employer's Name: _____

Insured's Insurance ID: _____ SS#: _____

Secondary Dental Insurance Information: Employee/Insured's Name: _____

Insured's Birth date: ___/___/_____ Relationship to patient: _____

Insurance Company Name: _____ Group Number: _____

Address: _____

Phone: _____

Employer's Name: _____

Insured's Insurance ID: _____ SS#: _____

CONSENT:

I certify that the above information has been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any dental services that may be necessary during diagnosis and treatment with my informed consent. I authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that I am financially responsible for payment in full of my account, as my insurance benefits may pay less than the actual bill for services.

_____ _____

Patient's/Guardian's signature Date