DORRI'S DENTAL

NEW PATIENT REGISTRATION

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ , Date of Birth: _____

Address

Street Address: _____

City: _____ , State: _____ , Zip code: _____

Telephone

Cell: _____ , Work: _____ , Home: _____

Email: _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Subscriber Name: _____

Social Security Number: _____ , Date of Birth: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer Name: _____ , Employer Phone Number: _____

Insurance Company: _____

Insurance Group: _____ , Insurance Phone Number: _____

* Please present your insurance card to be photocopied for our records.

RESPONSIBLE PARTY (if patient is a minor or different from patient listed above)

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ , Date of Birth: _____

Address

Street Address: _____

City: _____ , State: _____ , Zip code: _____

Telephone

Cell: _____ , Work: _____ , Home: _____

Email: _____

EMERGENCY CONTACT

Name: _____

Telephone (Cell): _____ , Telephone (Home): _____

AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluation and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to the practice and understand my insurance may pay less than the actual bill for services and that I am responsible for any services not paid or covered.

ELECTRONIC COMMUNICATIONS

I consent to receiving HIPAA-compliant electronic communications, such as email and text messages regarding treatment, payment, etc. I understand there is no obligation to receive these electronic communications.

Signature of Patient or Guardian: _____

Date: _____

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