Kaysville Dental – Patient Registration

Patient Information:

Name: Last First M. Init. Preferred: | Home Phone: ( ) | Cell Phone: ( )

Address: | City: | State: | ZIP:

Occupation: | Employer: | Height: | Weight: | DOB: | Sex: M F

SS# | Emergency Contact: | Relationship: | Home Phone: | Cell Phone:

Email Address: | Whom may we thank for referring you to our office:

Responsible Party Information: (Same as above ___)

Name: Last First M. Init. Preferred: | Home Phone: ( ) | Cell Phone: ( )

Address: | City: | State: | ZIP:

Occupation: | Employer: | DOB: | Sex: M F

Business Address: | Business Phone: ( )

Insurance Information

Primary Insurance Subscriber: Last First M. Init. SS# | DOB: | Relationship to Patient:

Employer: | Dental Insurance Co. | Subscriber # | Dental Insurance Co. Address:

Secondary Insurance Subscriber: Last First M. Init. SS# | DOB: | Relationship to Patient:

Employer: | Dental Insurance Co. | Subscriber # | Dental Insurance Co. Address:

Family Members/Dependents: Please list all family members/dependents that may be seen at this office and are covered under these policies. Please list their name, relationship to policy holder (spouse, son, daughter, etc.) and their birth dates.

Name:	Relationship:	Birth Date:
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____
4)_____	_____	_____
5)_____	_____	_____
6)_____	_____	_____
7)_____	_____	_____
8)_____	_____	_____

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize the payment of my dental insurance benefits directly to the dentist. I further authorize the release of any information concerning my (or my dependent's) dental care, advice, and treatment provided for the purpose of evaluating and administering claims for dental insurance benefits.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services not paid within 60 days from date of service, in whole or in part, by my dental insurance carrier.

_____ _____

Signature (Patient or Legal Guardian of Patient) Date