DEWITT DENTAL ASSOCIATES
DENTAL REGISTRATION FORM

PATIENT INFORMATION

Patient name ______________________________ Social Security Number ______________
last first middle initial

Address ______________________________
city state zip code

Phone ______________________________
home cell work

Sex ______ M ______ F Age __________ Birthdate ______________

______ minor ______ single ______ married ______ widowed ______ separated ______ divorced

If minor is student, name of college or university ______________________________
(Guardian information if patient under 18 years of age)

Parent/Guardian Name ______________________________

Employer ______________________________ Occupaton ______________

Employer address ______________________________

Employer phone ______________________________

Birthdate ______________________________ Social Security Number ______________

Spouse's name ______________________________

Spouse's employer ______________________ Spouse's work phone ______________

Who is responsible for this account? ______________________________

Relationship to patient? ______________________ Home phone ______________

INSURANCE INFORMATION

(In order to process your insurance we must have a copy of a current dental insurance card)

PRIMARY INSURANCE

Insurance Company ______________________________ Group # ______________

Subscriber's name ______________ SS# ______________ Birthdate ______________

Is patient covered by additional dental insurance? ______ yes ______ no

SECONDARY INSURANCE

Insurance Company ______________________________ Group # ______________

Subscriber's name ______________ SS# ______________ Birthdate ______________

Relationship to patient ______________________________

(OVER)

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and assign directly to DeWitt Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________________

Responsible party signature Relationship Date

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name ______________________________ Relationship ______________________________

Home Phone ______________________________ Work Phone ______________________________

Whom may we thank for referring you? ______________________________