REGISTRATION FORM

(Please Print)

Today's Date:_____

PATIENT INFORMATION

Last Name: First: Middle Initial:

Birth Date: / / SSN: Gender: □M □F

Street Address: City: Zip:

Phone (Home): (Cell): (Work):

E-mail: Preferred contact: □Phone □Text □E-mail

Employer:

Responsible Party (financially for minor child):

REFERRAL INFORMATION

Who may we thank for referring you to our practice?

□Current patient, friend □Current patient, relative □Coworker
□Website □Dental Office □Other

Name of person or office: _____

INSURANCE

Carrier Name:_____ ID# _____ Grp#_____
Employers Name: _____Insurance Co Phone# _____
Subscriber Name: _____Relationship to Subscriber: _____

In case of Emergency:

Name: _____ Relationship: _____ Phone# _____

AUTHORIZATION: I authorize Redland Family Dental or my insurance company to release any information required to process my claims. The above information is true to the best of my knowledge. Dental Services are a legal contract between patient and doctor. **Balances are due at the time of service**. I authorize my insurance benefits be paid directly to Redland Family Dental. Redland Family Dental reserves the right to charge for no show appointments, cancellations of less than 48 hours and/or attorney and collection fees on overdue accounts. **I understand that I am financially responsible for all dental fees even if my insurance does not pay**.

I have read and understand the contents of this form

Patient/Guardian Signature: *Date:*