LIFE DENTAL CARE

REGISTRATION FORM

Today's Date: [Date]			
PATIENT INFORMATION			
Patient's last name: First:	Middle:	Marital status:	
	Birthday: M ____D____ Y_____	[Birthday]	[Age] ⬤ M ⬤ F
Address:			
Social Security no.:	Home phone no.:	Cell phone no.:	
Occupation:	Employer:	Employer phone no.:	
E-mail	Driver license #:		
INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date:	Address (if different):	phone no.:
Is this person a patient here?	⬤ Yes ⬤ No	Is this patient covered by insurance?	⬤ Yes ⬤ No
Occupation:	Employer:	Employer address:	Employer phone no.:
Please indicate primary insurance:			

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	
Patient's relationship to subscriber:					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
[Friend or relative name]	[Relationship]	[Phone]	[Phone]

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LIFE DENTAL CARE or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of and treatment or examination rendered to me during the period of such Dental care to third party payors and/or other health practitioners.
I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.
I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

SIGNATURE

DATE