PENZ
DENTAL CARE

Patient Registration

Please complete all information that applies to you.

Date:

Patient name: First M.I. Last

Preferred name: Date of Birth: Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced If married, spouse's name:

Social Security Number:

How did you hear about Penz Dental Care?

CONTACT INFORMATION

Address:

City: State: Zip:

Telephone: Home: Mobile: Work:

Email:

Employer: Occupation:

Are you a full-time student? ☐ Yes ☐ No School:

Preferred contact method: ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email
(Check all that apply)

For Patients Under the Age of 18: PARENT OR RESPONSIBLE PARTY

Contact name: First M.I. Last

Address:

City: State: Zip:

Telephone: Home: Mobile: Work:

Email:

Employer: Occupation:

EMERGENCY CONTACT

Contact name: First M.I. Last

Telephone: Home: Mobile: Work:

DENTAL INSURANCE

Do you have dental benefits (insurance)? ☐ Yes ☐ No *If yes, we would like a copy of your policy card.*

Dental insurance company: _____

Subscriber ID number: _____

Group number: _____

Person responsible for this account: _____

Are you covered by another insurance company? ☐ Yes ☐ No

If yes, secondary insurance company: _____

Insurance Authorization:

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

Signature: _____ Date: _____

Print name: _____