PENZ DENTAL CARE

Patient Registration

Please complete all information that applies to you.

Date: 10-30-2018 13:54:11

Patient name: test (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: 10-30-2018 13:

Print name: