

Patient's name _____
LAST FIRST INITIAL

Date of birth _____ Date _____

How do you wish to be addressed? _____
single married separated divorced widowed

If child: guardian's name _____
LAST FIRST INITIAL

Address _____
City _____ State _____ Zip _____
Telephone: home _____ Bus: _____
email address _____
Patient/parent SSN _____
Patient/parent employed by: _____
Bus address: _____
Present position: _____
Spouse name: _____
Spouse employed by: _____
Bus address: _____
Present position: _____

Other family members in the practice _____
Purpose of this visit? _____
Person responsible for this account _____
Are you a full time college student? yes no
Name of college _____
Name and phone number of someone (not living with you) to notify in case of emergency _____

Whom may we thank for this referral? _____

YOUR PRIMARY DENTAL INSURANCE COVERAGE

Employee Name _____
Employee D.O.B. _____
Employer _____
Name of insurance co. _____
Address _____
Telephone # _____
Program or policy # _____ Group# _____
SSN of policy holder _____

YOUR SECONDARY DENTAL INSURANCE COVERAGE

Employee Name _____
Employee D.O.B. _____
Employer _____
Name of insurance company _____
Address _____
Telephone # _____
Program or policy # _____ Group# _____
SSN of policyholder _____

PERSONAL INFORMATION

INSURANCE INFORMATION

RELEASE: all information held by this office is considered confidential, and will not be released without prior consent

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to South Shore Dental Group.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payments of all accounts, and accept the responsibility for monitoring insurance payments and plan limitations.. I hereby agree to be responsible for payment of services not paid, in whole or in part by my dental insurance company.
I attest to the accuracy of the information on this page.

PATIENT / GUARDIAN'S SIGNATURE _____ DATE _____

**SOUTH SHORE DENTAL GROUP
PATIENT REGISTRATION**

