



Patient Registration Form

Patient Information

Date _____ Soc. Security # _____

Name _____
First Middle Last

Street Address _____

City _____ State _____ Zip _____

Birthdate _____ Gender: Male Female

Check Appropriate Box: Minor Single Married
 Divorced Widowed Separated

Occupation _____

Employer/School: _____

Employer/School address: _____

City _____ State _____ Zip _____

Spouse's name _____ Phone # _____

Spouse's Employer _____

How did you hear about our office? _____

Contact Information

Home # _____

Work # _____

Cell # _____

Email _____

How do you prefer to be contacted?

- Home Telephone
- Work Telephone
- Email
- Text Message

In Case of Emergency, whom may we contact?

Name: _____

Relationship _____

Home # _____

Work # _____

Cell # _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address (if different from above) _____

Home phone _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office Yes No

Dental Insurance Information

Name of insured _____ Relationship to patient _____

Insurance Co. _____ Name of employer _____

Group # _____ Policy # _____

Subscriber Birthdate _____ Subscriber SSN: _____

Do you have any additional insurance: Yes No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Insurance Co. _____ Name of employer _____

Group # _____ Policy # _____

Subscriber Birthdate _____ Subscriber SSN: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Tranquility Dental Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I authorize the use of my signature on all insurance submissions whether manual or electronic.

Tranquility Dental Wellness Center may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services.

X _____
Signature of patient (or parent, if minor)

Printed Name

Date