

PATIENT NUMBER

© 1996 Wisconsin Dental Association
(800) 243-4675

PATIENT'S NAME Last First Initial

Date Date of Birth Male Female

IF CHILD: PARENT'S NAME Last First Initial

DENTAL INSURANCE 1ST COVERAGE

HOW DO YOU WISH TO BE ADDRESSED Single Married Separated Divorced Widowed Minor

EMPLOYEE NAME

RESIDENCE - STREET

EMPLOYEE DATE OF BIRTH

CITY

EMPLOYER # YRS.

BUSINESS ADDRESS

NAME OF INSURANCE CO.

TELEPHONE: RES. BUS.

ADDRESS

PATIENT/PARENT EMPLOYED BY

TELEPHONE

PRESENT POSITION HOW LONG HELD

PROGRAM OR POLICY #

SPOUSE/PARENT NAME

UNION LOCAL OR GROUP

SPOUSE EMPLOYED BY

SOCIAL INSURANCE NO.

PRESENT POSITION HOW LONG HELD

DENTAL INSURANCE 2ND COVERAGE

WHO IS RESPONSIBLE FOR THIS ACCOUNT

EMPLOYEE NAME

DRIVERS LICENSE NO.

EMPLOYEE DATE OF BIRTH

METHOD OF PAYMENT: Insurance Credit Card Cash

EMPLOYER # YRS.

PURPOSE OF CALL

NAME OF INSURANCE CO.

OTHER FAMILY MEMBERS IN THIS PRACTICE

ADDRESS

WHOM MAY WE THANK FOR THIS REFERRAL

TELEPHONE

PATIENT/PARENT SOCIAL INSURANCE NO.

PROGRAM OR POLICY #

SPOUSE/PARENT SOCIAL INSURANCE NO.

UNION LOCAL OR GROUP

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU

SOCIAL INSURANCE NO.

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize 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 authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. 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 carrier or payor 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 payment of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE DATE

REGISTRATION