REGISTRATION FORM

FAMILY DENTAL CARE OF OAK PARK

FAMILY DENTAL CARE OF OAK PARK

PERSONAL INFORMATION

Patient Name:

Date : D D M M Y Y Y Y

Date Of Birth : D D M M Y Y

Driver License : Yes No

Relationship to Patient : Single Married Divorce Others

Full Address :

Postcode :

City / Country :

Phone Number :

E-Mail :

How would you like to recieve future appointment reminders? Text Phone Email Other

Referred By :

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:

Relationship to Patient : Spouse Parent Child Others

E-Mail :

Phone Number :

PLEASE COMPLETE BACK SIDE OF FORM

REGISTRATION FORM

— FAMILY DENTAL CARE OF OAK PARK

FAMILY DENTAL CARE OF OAK PARK

INSURANCE INFORMATION

☐ Check this box if you do not have insurance

Subscriber Name:

Date of Birth : D D M M Y Y Y Y

Insurance Company: :

Subscriber Number: :

Social Security Number: :

Group Number :

Relationship to Patient : ☐ Self ☐ Spouse ☐ Dependent ☐ Others

Employer: :

E-Mail :

Driver License : ☐ Yes ☐ No

Gender : ☐ Male ☐ Female

SECONDARY INSURANCE INFORMATION - IF APPLICABLE

Subscriber Name:

Date of Birth : D D M M Y Y Y Y

Insurance Company: :

Subscriber Number: :

Social Security Number: :

Group Number :

Relationship to Patient : ☐ Self ☐ Spouse ☐ Dependent ☐ Others

Employer: :

I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my dependants during the period of such dental care to third-party payors and/or other healthcare practitioners. I authorize and hereby request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all remaining balances

Signatures of Patient or Responsible Party: _____

THANK YOU FOR YOUR INFORMATION