PATIENT REGISTRATION

All information is confidential

Name:			
First:	Last:	Middle:	Sex: M F
Birth date:	SSN:	Height:	Weight:
Marital Status: Married Single Separated divorced	Email Address:		
Phone Numbers: Mobile:	Work:	Home:	
Home Address:			
Street:	Apt. #:	City:	State: Zip Code
Employer Name			
Address:			
Nearest Relative not living with you: Name:			
Address:		Phone #:	

Dental Insurance Information

Primary Insurance:	Group #:	Phone #:
Secondary Insurance:	Group #:	Phone #:
Subscriber's Name:	SSN:	Birth date:

Responsible Party

Name:			Relationship to patient:
Birth date:	SSN:	Employer:	
Home address:			
Phone numbers: Mobile:		Work:	Home:

How did you hear about us?

Google	Yahoo	MSN	Yelp	Phone book	Magazine	Drive by
Another Patient: Name:						
Other:						

Notice Of Responsibility

I understand that I am personally responsible for the cost of my dental treatment based Dental Implant Centers' fee schedule. I agree to pay accordingly, at the time of service (unless otherwise pre-arranged) for any dental treatment rendered. It has been explained to me that Dental Implant Centers is not responsible for my dental insurance benefits' re-imbursement. I further understand that Dental Implant Centers will bill my dental insurance only as a courtesy and, by no means is responsible for the amount my insurance will pay.

Notice of Privacy Practices

I hereby acknowledge that I have read, understood, and received a copy of Dental Implant Centers' Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have had regarding this notice.

Signature of Patient or Guardian: _____ **Date:** _____