

Patient Registration

Dr ____ Mr ____ Mrs ____ Ms ____

First Name _____ Last _____ Middle Initial _____ Preferred

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____ Cell _____

E-mail _____

Social Security _____ Date of Birth _____

Referred by _____

If full-time student, school name? _____

Dental Insurance

Policy Holder Name _____ Date of Birth _____ Relationship _____

Social Security # _____ Employer _____

Insurance Company Name _____ Group # _____

Insurance Address _____ City _____ State _____ Zip _____

Do you have **Secondary Dental Insurance**? Yes No

Do you receive e-mail correspondence? Yes No

Do you receive text messages? Yes No

Emergency Contact

Name _____ Relationship _____

Home _____ Work _____ Cell _____

I authorize the above individual(s) to be contacted in the event of an emergency.

I understand that treatment information may be discussed for my welfare.

Method of Payment: Cash ____ Check ____ MasterCard ____ Visa ____ *Payment Plan ____

*Requires authorization

Authorization

I authorize payment of any insurance benefits otherwise payable to me, to be paid to the office of Drs. Salisbury & Driscoll, D.D.S., P.A. I authorize the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my (my child's) dental /medical histories and other information about my dental treatment to third party payers and/or other health professionals.

Signature of Patient/Legal Guardian: _____ **Date:** _____