WILLOW RIDGE DENTAL CARE – PATIENT REGISTRATION

(Please print legibly)

PERSONAL INFORMATION: ❒Please text me appointment confirmations

Name: _____ SS #: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ ❒I would like to receive e-mail correspondences

Birth date: _____ Sex: ❍Male ❍ Female **Referred by:** _____

Marital Status: ❍Married ❍Single ❍ Divorced ❍Separated ❍ Widowed

EMERGENCY CONTACT: _____ Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship: _____ SS #: _____

Address: _____ Birth Date: _____

City, State, Zip: _____ _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DENTAL INSURANCE INFORMATION:

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ Employee Birth Date: _____

Employer: _____Policy #: _____ SS #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ Employee Birth Date: _____

Employer: _____ Policy #: _____ SS #: _____

All information given above will be held in the strictest of confidence. I acknowledge that I was offered a copy of Willow Ridge Dental Care's Notice of Privacy Practices and Willow Ridge Dental Care's Written Financial Policy.

- I authorize Willow Ridge Dental Care to administer medications and anesthetics and to perform diagnostic imaging and therapeutic dental procedures as needed for appropriate dental care.
- I am responsible to inform Willow Ridge Dental Care of any changes in my information.
- I am responsible for all costs of my dental treatment regardless of insurance coverage.
- I understand any account balance over 90 days will be assessed a finance charge.

Assignment of Insurance: I authorize release of any information to third party payors and/or health professionals and for training purposes. I authorize Willow Ridge Dental Care to receive assignment of all current and future insurance benefits as needed.

Signed: _____ Date: _____