PALATINE DENTAL ASSOCIATES
PATIENT REGISTRATION

PATIENT INFORMATION **Date**_____

Name:_____O Single O Married O Divorced O Widowed
Age:_____Birthdate:_____Sex: O Male O Female Social Security #:_____
Home Address:_____City, State, Zip:_____
Home Phone:_____Work Phone:_____
Cell Phone:_____E-Mail Address:_____
Employer:_____Employment Status: O Full-Time O Part-Time O Retired
Employers Address:_____Occupation:_____
School Name:_____Location:_____Student Status: O Full-Time O Part-Time
In case of an emergency, whom may we contact? Name:_____Phone:_____
Whom may we thank for referring you?:_____

RESPONSIBLE PARTY (if someone other than the patient)
Name:_____Relationship:_____
Home Address:_____City, State, Zip:_____
Home Phone:_____Work Phone:_____Cell Phone:_____
Birth Date:_____Social Security #:_____
Employer:_____Employment Status: O Full-Time O Part-Time O Retired
Employer's Address:_____Occupation:_____

DENTAL INSURANCE INFORMATION Do you have dental insurance? O Yes O No

Primary
Insurance Company:_____Employer:_____
Dental Claims Mailing Address:_____Group #_____
Name of insured:_____Insured birthdate:_____
Insured Social Security #:_____
Relationship to patient: O Self O Spouse O Parent O Other Insured phone:_____

Secondary
Insurance Company:_____Employer:_____
Dental Claims Mailing Address:_____Group #:_____
Name of insured:_____Insured birthdate:_____
Insured Social Security:_____
Relationship to patient: O Self O Spouse O Parent O Other Insured phone:_____

We plan all appointments carefully in advance and strive hard to stay on schedule and minimize waiting. Please help us by being on time and also by calling us at least 24 hours in advance if you need to change an appointment. Unless we are notified that you can't make your dental appointment, you may be subject to a charge for missed appointments.

I am responsible for this account, including all balances unpaid by my insurance. Past due accounts for which no financial arrangements have been made, may be subject to a 1.5% monthly service charge.

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Patient (Parent) Signature