Registration

English Rows Dental Group

Patient's Name _____ Date of Birth: _____
Parent/Guardian's Name: _____ M / F
Preferred Name: _____ Salutation: _____
Address: _____
_____
_____
Phone: _____ Fax: _____
Business Address: _____ Cell Phone: _____
Business Phone: _____ Email: _____
Guarantor: _____
Drivers license No. _____
Payment Method: _____
Other family members: _____
Referral from: _____
SSN: _____
Spouse/Parent SSN: _____
Emergency Contact: _____

Primary Insurance Coverage

Employee Name _____
DOB _____
Employer Name _____
Years Employed _____
Insurance Company _____
Address _____
_____
Telephone _____
Program or policy number _____
SSN: _____
Union Local or Group _____

Secondary Insurance Coverage

Employee Name _____
DOB _____
Employer Name _____
Years Employed _____
Insurance Company _____
Address _____
_____
Telephone _____
Program or policy number _____
SSN: _____
Union Local or Group _____

Consent

I consent to the diagnostic procedures and treatments by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

Sign: _____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.

Patient's or Guardian's signature

Sign: _____ Date_____