PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial _____

Preferred Name: _____

RESPONSIBLE PARTY, IF SOMEONE OTHER THAN THE PATIENT (PARENT OR LEGAL GUARDIAN):

First Name: _____ Last Name: _____ Middle Initial _____

Address: _____ Apt., Suite, Lodge No. _____

City: _____ State _____ Zip Code: _____

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

Birth Date: _____ Social Security: _____ Driver's License: _____

Email Address: _____

PATIENT INFORMATION:

Address: _____ Apt., Suite, Lodge No. _____

City: _____ State _____ Zip Code: _____

Sex: _____ Male _____ Female

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

Home Phone: _____ Work Phone: _____ Ext. _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

Email Address: _____ Preferred Pharmacy: _____

Mississippi Medicaid ID Number: _____ / For Private Insurance, Please See Next Page

Please list additional parents, legal guardians or others who may have access to patient records:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

_____

Signature of patient (or parent/legal guardian if a minor) Date