ALLEN VALLEY DENTAL
EXCELLENCE IN DENTISTRY

Today's Date _____

PATIENT INFORMATION

Name _____
Last First MI

How do you wish to be addressed? _____

Home Address _____

_____
City State ZIP

Phone: Home _____
Business _____
Cell _____

Email _____

Birth date _____

Social Security # _____

Marital Status
☐ single
☐ married
☐ divorced
☐ widowed

Sex
☐ male
☐ female

Are any family members patients with us? _____
Who? _____

Whom to thank for referring you? _____

Employer _____

Occupation _____

INSURANCE & BILLING INFORMATION

We provide the courtesy of filing your insurance claims on your behalf. Please provide us with your Insurance ID card at time of registration.

Dental Insurance Company _____

Employer Name _____

Person responsible for account _____

Relation to patient _____

Insurance ID Number _____

Group Number _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental care _____

PLEASE READ & INITIAL THE FOLLOWING

____ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care

____ I understand that a fee may be charged for broken appointments canceled with less than 24 hour notice.

____ I authorize the release of any information concerning my healthcare, advice and treatment to another dentist and/or insurance company to secure payment of benefits.

____ I understand that all professional services are charged directly to the patient and that I am responsible for payment of fees including all collection/attorney fees.

_____ _____

Responsible party signature **Date**

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