

# WELCOME TO DR. DENIS C. SCHARINE'S OFFICE

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

How do you wish to be addressed? \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed  Minor

Residence-Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License Number \_\_\_\_\_

Type of Payment: Insurance  Cash  Credit Card

Purpose of Visit \_\_\_\_\_

Other Family Members at our practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/Parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency who does not live with you \_\_\_\_\_

## DENTAL INSURANCE

### 1st Coverage

Employee Name \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or Policy # \_\_\_\_\_

SSN \_\_\_\_\_

Union Local or Group \_\_\_\_\_

### 2nd Coverage

Employee Name \_\_\_\_\_ DOB \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or Policy # \_\_\_\_\_

SSN \_\_\_\_\_

Union Local or Group \_\_\_\_\_

### CONSENT:

I consent to the diagnostic procedures and treatment 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.

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 payor of my dental benefits may pay less than the actual bill for service, 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 payor.

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

PARENT'S OR GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_

## REGISTRATION FORM