WELCOME TO DR. DENIS C. SCHARINE'S OFFICE

Date_____

Patient's Name_____ Date of Birth_____ O Male O Female

How do you wish to be addressed?_____

Single O Married O Separated O Divorced O Widowed O Minor O

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 O Cash O Credit Card O

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.

PATIENT'S OR GUARDIAN'S SIGNATURE

_____
_____

DATE_____

REGISTRATION FORM