MANSFIELD DENTAL CENTER

Patient Registration

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender *(PLEASE CIRCLE ONE)*: Male / Female Soc Sec #: _____

Home address: _____

ADDRESS *CITY* *STATE* *ZIP*

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

Email Address: _____ Status *(PLEASE CIRCLE ONE)*: Minor / Single / Married / Divorced / Separated / Widowed

Drivers License #: _____ State: _____ Appointment Reminders *(PLEASE CIRCLE WHICH YOU WOULD PEREFER)*: Call / Email / Text

If patient is a minor, we will need parent or guardian information: _____

Name DOB Relation

Patients, Parents, or Guardians Employer information:

Place of Employment: _____ Occupation: _____

Emergency Contact:

In case of an emergency, who should we contact? _____ _____ _____

NAME PHONE # RELATION

HOW DID YOU HEAR ABOUT US?

In a continuing effort to better serve our patients, please take a moment and circle how you heard about our office.

Referred by an existing patient, if so by whom: _____ Google Advertisement

Referred by a doctor, if so by whom: _____ Social Media Our Website

Word of mouth / friend Mailer Location / Sign

Person Responsible for Your Dental Investment:

Name: _____ Home Phone #: _____

Relation: _____ Work Phone #: _____

Insurance Information:

Insurance Company Name: _____ Insured's ID # or Soc Sec #: _____

Group #: _____ Phone #: _____ Insured's Employer: _____

Insured's Name: _____ Date of Birth: _____ Relation: _____

Assignment and Release:

I certify that I, and my dependents(s) have insurance coverage with _____ and assign directly to the dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____ Date: _____

Signature of Patient, Parents, Guardian, or Representative