Cottonwood
DENTAL CARE, PA
ADULT PATIENT REGISTRATION

Patient Information
[ ] Child [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced Sex_____

Last Name: _____First Name: _____ MI ____

Birth Date: _____ S.S. # _____-_____-_____ DL#_____

Mailing Address: _____, Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Other: _____

If Married, Spouse: _____ Spouse's Birth Date: _____

Spouse's SS#_____

Whom should we call in case of an emergency? _____

Relationship _____Phone:_____

*Whom may we thank for referring you? _____

Employment Information
Patient employed by: _____ Phone: _____

Business Address: _____

Present Position: _____ How Long Held: _____

Spouse employed by: _____ Phone: _____

Business Address: _____

Insurance Information
Please present card to the front desk to copy the card.
1) If you have insurance, name and address of primary insurance company:

_____
Policy #: _____ Group #: _____
Policyholder's name_____ Date of Birth_____

Financial Information
PAYMENT IS DUE IN FULL AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.
I understand that I am financially responsible for all charges on date of service whether or not paid by insurance. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature: _____Date:_____

I will be paying my account with……
_____Check _____ Cash _____ Credit Card [ ] Visa [ ] MasterCard