PAYMENT BY: CASH_____ INSURANCE_____ DENTACARE_____ TITLE 19_____ CONTRACT_____

ACCOUNT HOLDER:	SPOUSE: If held, secondary dental insurance coverage must be listed.
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY, STATE:	CITY, STATE:
ZIP CODE:	ZIP CODE:
HOME PHONE:	HOME PHONE:
WORK PHONE:	WORK PHONE:
PHONE OF NEAREST RELATIVE:	
BIRTH DATE: / / SEX:	BIRTH DATE: / / SEX:
SOCIAL SEC. NO.:	SOCIAL SEC. NO.:
EMPLOYER:	EMPLOYER:
DENTAL INS. CO.	DENTAL INS. CO.
MAIL TO:	MAIL TO:
GROUP # OR LOCAL #	GROUP # OR LOCAL #
SUBSCRIBER #	SUBSCRIBER #
MEDICAL ASSIST. #	

MEDICAL INSURANCE INFORMATION

PHYSICIAN'S NAME:	PHYSICIAN'S NAME:
TELEPHONE NO.:	TELEPHONE NO.:
MEDICAL INS. CO.:	MEDICAL INS. CO.:
MAIL TO:	MAIL TO:
GROUP #	GROUP #
SUBSCRIBER #	SUBSCRIBER #

I AUTHORIZE RELEASE OF ANY INFORMATION REQUIRED IN THE COURSE OF EXAMINATION AND/OR TREATMENT. I PERMIT PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE DENTIST FOR HIS SERVICES RENDERED. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR SERVICES NOT COVERED BY INSURANCE BENEFITS.

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

PATIENT ACCOUNT REGISTRATION