Welcome to Comfort Dental Care Registration Form

Patient Name _____

What do you prefer to be called ? _____

Male ☐ Female ☐

Birth date _____ Age _____

SS#_____

Mailing Address

Street_____

City _____ St _____ Zip _____

Please check best number to call when we need to reach you.

Home # _____ ☐

Cell # _____ ☐

Work # _____ ☐

Email _____

Occupation _____

Status: ☐Minor ☐Single ☐Married ☐Other

Referred by _____

Insurance

Primary DENTAL Insurance

Insurance Co_____

Group # _____

Insured Name _____

Insured SS# _____

Insured ID# _____

Birth date of insured _____

Relationship to insured _____

Employer Name _____

Employer Address _____

_____

Employer Phone # _____

Secondary DENTAL Insurance

Insurance Co_____

Group # _____

Insured Name _____

Insured SS# _____

Insured ID# _____

Birth date of insured _____

Relationship to insured _____

Employer Name _____

Employer Address _____

_____

In Case of Emergency

Whom should we contact?

Name _____

Relationship _____

Home Phone _____

Work Phone _____

Physician

Name _____

Phone _____

Account Information

Person ultimately responsible for account

Name _____

Relationship _____

Billing Address _____

_____

SS# _____

Drivers License # _____

Home Phone _____ Work Phone _____

I hereby authorize assignment of my insurance rights and benefits directly to Comfort Dental Care, PA for services rendered. I fully understand I am solely responsible for any balance not paid for by my insurance company. I authorize the release of all information necessary, and the use of this signature, on all insurance submissions.

Signature _____ Date _____