Cary Periodontics & Implant Dentistry

PATIENT REGISTRATION

Name:_____ Date of Birth: _____ Age:_____

Address:_____ City:_____ State:_____ Zip: _____

Home Phone #:_____Work Phone#:_____ Cell Phone #:_____

Preferred Phone # (choose one): Home Work Cell Social Security #_____

Email Address:_____ Driver's License #:_____

Sex: M F Marital Status: S M D O Spouse's Name:_____

Employer:_____ Occupation:_____

Dentist's Name:_____ Phone#:_____

Emergency Contact Name: _____Phone#:_____

Relationship to Patient:_____

If patient is a minor, who is responsible for the account:_____

Address:_____ Phone #:_____

DENTAL INSURANCE INFORMATION AND AUTHORIZATION

DENTAL INSURANCE (insurance in your name or insurance to be filed first)

Dental Insurance Company Name:_____ Phone #:_____

Address:_____ City, State, & Zip:_____

Name of Policyholder:_____ Date of Birth:_____

ID# or SSN#_____ Group #:_____ Employer:_____

Relationship to Patient:_____

SECONDARY DENTAL INSURANCE (your spouse's insurance or insurance to be filed after the first)

Dental Insurance Company Name:_____ Phone #:_____

Address:_____ City, State, & Zip:_____

Name of Policyholder:_____ Date of Birth:_____

ID# or SSN#_____ Group #:_____ Employer:_____

Relationship to Patient:_____

I hereby authorize the release of any pertinent clinical or radiographic information by Dr. Michael J. Brenegan or his staff to the above mentioned insurance company or companies for the purpose of assisting in the processing of my insurance claims.

SIGNED:_____DATE:_____