



6841 Coit Road Plano, TX 75024 (972) 618-5000

Registration and Health History *Patient Information*

Today's Date: _____ Reason for this visit: _____

Patient's Name: _____ DOB: _____ SS#: _____
(Last) (First) (MI)

Address: _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

DL # _____ Sex: _____ Marital Status: _____

Employer: _____ Email: _____

Person to contact in an emergency _____ Home # _____ Work # _____

If patient is a minor, give parent or guardian's name _____

Whom may we thank for your referral? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____

Insured's SS#: _____ DOB: _____

Insured's Address (if different than above): _____

City _____ State _____ Zip _____

Insured's Employer: _____ Insurance Company: _____

Claims Address: _____

Phone #: _____ Group #: _____ Effective Date of coverage: _____

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me.

Signed _____ **Date** _____

(OVER)

