# Patient Registration Information

A.Y. Family DENTAL

**Welcome to our practice!**

Date_____

Name_____ _____
First Mi Last Preferred Name

---

Address_____City_____State_____Zip_____

Birthdate_____ Home Phone_____ Work Phone_____

E-Mail_____ Cell Phone_____ Text? Y or N

How do you prefer to receive your appointment reminders?

Text to cell phone ☐ Email ☐ Call my home phone ☐

---

Whom May We Thank for Referring You? _____

Person to Contact in Case of an Emergency _____ Phone _____

---

**Responsible Party (if someone other than the patient)**

First Name: _____ Last Name: _____

Relationship to Patient: _____ Birthdate: _____

Address: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

---

**Insurance Information**

Name of Insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Co: _____ Group #: _____ Member ID#: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

(*Where claims should be mailed to*)

---

**Authorization and Agreement to Pay For Services Rendered**

I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependants.

**X**_____ _____
Signature of patient or parent/guardian if minor Date