Welcome! *So that we may provide you with the best possible care, please complete the enclosed Registration and Medical/Dental History forms. All information is completely confidential.*

Patient Information

Patient Name _____ How do you wish to be addressed? _____
FIRST INITIAL LAST

Address _____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Home Telephone _____ Business Telephone _____ Date of Birth _____

Social Security _____ ❑ Female ❑ Male ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other

In case of emergency, contact _____ Telephone _____

Whom may we thank for this referral? _____

Account Information

Person responsible for account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip Code _____

Home Telephone _____ Business Telephone _____ ext. _____

Date of Birth _____ ❑ Female ❑ Male Social Security _____

Services will be paid by ❑ Cash at each appointment ❑ Check ❑ VISA/Mastercard ❑ Insurance ❑ Other

Insurance Information

Primary Carrier

Employee Name _____ Date of Birth _____ Social Security No. _____

Employer _____ Address _____ Telephone _____

Insurance Co. _____ Address _____ Telephone _____

Group Number _____ Policy Number _____ Union/Local Number _____

Secondary Carrier

Employee Name _____ Date of Birth _____ Social Security No. _____

Employer _____ Address _____ Telephone _____

Insurance Co. _____ Address _____ Telephone _____

Group Number _____ Policy Number _____ Union/Local Number _____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims of insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I authorize payment of insurance benefits directly to the dentist.
I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.
Payment for dental services provided in this office for myself and my dependents is due and payable at the time services are rendered unless financial arrangements have been made. I understand that a 1-1/2% finance charge (18% annual percentage rate) on unpaid balance over 90 days will be added to my account.
I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____ Date _____

ACQUAINTANCE FORM

Dental Associates, P.A. 2205 S. Solano Drive Las Cruces, New Mexico (505) 522-7320