



Patient Registration

Welcome to Kneeland Dental Care. We appreciate the confidence you place in us to provide you with dental services. To assist us in serving you, please complete the following forms. The information provided on these forms is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Date: _____

Patient Name: First _____ M _____ Last _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____

Gender: Female Male Family Status: Married Single Child Other: _____

Parent/Guardian (If minor): _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Cell Phone #: _____

E-mail Address: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: _____

Is any other family member presently under our care?

Name: _____ Relationship: _____

Whom may we thank for referring you? _____

Person Financially Responsible for Account Payment: _____

Relationship to Patient: _____ Phone #: _____

Billing Address (if not same as listed above): _____

City: _____ State: _____ Zip Code: _____

Insurance Information

Primary Insurance

Secondary Insurance

Date of Birth: _____

Policy Holder: _____

Social Security #: _____

Social Security #: _____

Relationship to Patient: _____

Relationship to Patient: _____

Insurance Company: _____

Insurance Company: _____

Insurance Address: _____

Insurance Address: _____

Insurance Phone #: _____

Insurance Phone #: _____

Policy #: _____

Policy #: _____

Group #: _____

Group #: _____

Employer: _____

Employer: _____

Insurance Agreement:

I certify that the insurance information above is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations, and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and myself. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

Signature of responsible party

Print name

Date