kneeland dental care

# 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**

Policy Holder: _____
Date of Birth: _____
Social Security #: _____
Relationship to Patient: _____
Insurance Company: _____
Insurance Address: _____
_____
Insurance Phone #: _____
Policy #: _____
Group #: _____
Employer: _____

**Secondary Insurance**

Policy Holder: _____
Date of Birth: _____
Social Security #: _____
Relationship to Patient: _____
Insurance Company: _____
Insurance Address: _____
_____
Insurance Phone #: _____
Policy #: _____
Group #: _____
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