South Arlington
DENTAL CARE
Creating Smiles with a Gentle Touch

PATIENT REGISTRATION

Today's Date: _____ DOB: _____ Patient Social Security #_____

Patients Name_____
(Last) (First) (Middle Initial) (Preferred)

Address_____

City_____State_____Zip_____

Driver's License # _____ Male Female Single Married Child Other _____

Home Phone #_____Work Phone #_____Other #_____

Email address_____

Best form of communication: I prefer ☐email ☐text ☐phone call

Employer_____Occupation_____

Employer Address_____

In Case of Emergency Contact:

Name_____Relationship_____

Address_____ Contact #_____

How did you hear about our office? _____

Account Information:

Individual Responsible for this account _____
(Last) (First)

Relationship to patient _____ DOB: _____Social Security #_____

Address_____

City_____State_____Zip_____

Employer_____ Group #_____

Insurance Carrier _____Customer Service #_____

Claims Mailing Address _____

City_____State_____Zip_____

Any additional Insurance coverage:

Relationship to patient _____DOB: _____Social Security #_____

Employer _____ Group #_____

Insurance Carrier_____ Customer Service #_____

Claims Mailing Address_____

City_____State_____Zip_____

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorize Dr. Shah to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Shah to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Shah to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Shah choose and employ such assistance as She deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

_____ _____

Patient/Guardian Signature **Date**