Patient Registration Form **Date of Appointment:** _____

PERSONAL INFORMATION **Referred By:** _____

Patient Last Name: _____ **First:** _____ **Middle initial:** _____

(Preferred name: _____) **DOB:** _____/_____/_____ ☐Single ☐Married ☐Child ☐Other

SS# _____ **Sex**: ☐ M ☐ F ☐ Non-Binary

Address:_____

City: _____ State _____ Zip _____

Telephone (Home) _____ (**Cell**) _____ **E-mail:** _____

Emergency Contact (Name/Relationship) _____ (Phone) _____

Responsible Party/Guardian

Last Name: _____ First: _____

Address:_____

City: _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

E-mail_____

INSURANCE INFORMATION

Subscriber Name (If other than patient) _____

Insurance Company _____ Subscriber DOB: _____/_____/_____

Subscriber/Member ID#: _____ Group #: _____

Insurance Co. phone #: _____

RECORDS INFORMATION RELEASE

I, _____ , hereby give consent for Marietta Dental & Implant Center to disclose and/or discuss my or my dependent party's personal information with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

NOTICE OF INFORMATION CHANGE

I, (Patient/Guardian Name) _____ , understand that it is my responsibility to notify Marietta Dental & Implant Center of any changes to my or my dependent's personal, medical, or insurance information **PRIOR TO ANY FUTURE APPOINTMENTS**. I also understand that failure to do so may cause lengthened appointment times and/or may incur large, out-of-pocket balances due to rejected insurance claims.

Signature _____ **Date** _____