CRESTVIEW DENTAL

46600 Romeo Plank
Macomb, MI 48044
(586) 226-9000

WELCOME:

Age: _____ Date: _____

Patient Name: _____ Date of Birth: _____ □ Male □ Female

If Child: Parent's Name: _____

How do you wish to be addressed? _____

Single☐ Married☐ Separated☐ Divorced☐ Widow☐ Minor☐

Residence-Street: _____

City: _____ State: _____ Zip: _____

Business Address: _____

Telephone: Res. _____ Bus. _____

Fax: _____ Cell Phone: _____

Email: _____

Employed By: _____

Present Position: _____

How Long Held: _____

Spouse / Parent Name: _____

Spouse employed by: _____

Present Position: _____

How Long Held? _____

Who is responsible for this account? _____

Driver License No: _____

Method of Payment: Insurance ☐ Cash☐ Credit Card☐

Purpose of visit? _____

Other family members in this practice: _____

_____

Whom may we thank for this referral: _____

Employee Name: _____ DOB: _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency (not living with you):

_____

Dental Insurance 1st Coverage

Employee Name: _____ DOB: _____
Relationship to patient: _____
Employer Name: _____ Yrs: _____
Name of Insurance Co: _____
Address: _____

_____
Telephone No : _____
Program or policy #: _____
Social Security No: _____
Union Local or Group: _____

Dental Insurance 2nd Coverage

Employee Name: _____ DOB: _____
Relationship to patient: _____
Employer Name: _____ Yrs: _____
Name of Insurance Co: _____
Address: _____

_____
Telephone No : _____
Program or policy #: _____
Social Security No: _____
Union Local or Group: _____

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be in effect until I revoke it in writing.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payer.
I attest to the accuracy of the information on this page,
PATIENT'S OR GAURDIAN'S SIGNATURE:

_____ Date: _____

REGISTRATION