Name______________________________________
last first middle

Adult Patient Registration

____
Legal First Name Preferred M.I. Last Name

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

____
Home Address Apt# City State Zip Code

____
Social Security Number Birth Date Home Phone Cell Phone Email

Who will be financially responsible for this account? ______________________________

Account will be paid today by: ❑ Cash ❑ Check ❑ Credit Card ❑ Care Credit

____
Occupation Employer City State Zip Code Work Phone How Long Held

____
Nearest Relative Not Living With You Address City State Zip Code Phone

If you are married, please complete the following:

____
Spouse's Legal First Name Preferred M.I. Last Name

____
Home Address (If different from above) Apt# City State Zip Code

____
Social Security Number Birth Date Home Phone Cell Phone Email

____
Occupation Employer City State Zip Code Work Phone How Long Held

Whom may we thank for referring you to us?

____
Name Relationship Phone

Is any member of your immediately family a patient here? ❑ Yes ❑ No

If yes, what is his or her name? ______________________________________

Partners In Dental Care • 2565 Forest Hill Avenue SE Ste 200 • Grand Rapids, MI 49546-7535
p 616.949.0230 • f 616.949.1125 • e office@partnersindentalcare.com • www.partnersindentalcare.com

Name____________________________________
last first middle

Please complete the following section if you have dental insurance:

____
Name of Insured/Subscriber (Primary) Insurance Company

____
Employer Group Number

____
Name of Spouse's Dental Insurance Company (Secondary) Employer Group Number

We make every effort to keep the cost of your dental care down. You can help by paying for treatment at the time of your visit. Payment for services is due at the time services are rendered unless financial arrangements are made with our business staff. You may take advantage of our 5% courtesy savings when paying your account in full (by cash or check) on day of service.

If you have dental insurance, remember that your insurance is a contract between you, your employer, and the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. The insurance co-payment, that portion of the fee which is payable by the patient, is due at the time of service.

Authorization and Release:

I authorize the doctor to release any information including the diagnosis and the records on any treatment or examination rendered on my behalf during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf.

____
Signature of Patient (or parents of minor) Date

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