Verma
COSMETIC & FAMILY DENTISTRY
Be healthy. Live well. Smile often.

4701 N. Galloway Avenue, Mesquite, TX 75150 • P/ 972.279.9494 • F/ 972.270.9126 • www.texasdental.net

PATIENT REGISTRATION

Date: _____

Name _____
Last *First* *Initial*

If Child:

Parents Name _____
Last *First* *Initial*

How Do You Wish To Be Addressed? _____

Date of Birth _____ Sex ❑ Male ❑ Female

Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor

Residence Address _____
Street *City* *State* *Zip*

Business Address _____
Street *City* *State* *Zip*

Telephone: Res. (_____) _____ Bus. (_____) _____ Cell (_____) _____

Patient/Parent Employed By _____

Present Position _____ How Long Held? _____

Spouse/Parent Name _____

Spouse Employed By _____

Employers Address _____
Street *City* *State* *Zip*

Who Is Responsible For This Account? _____

Drivers License Number _____

Method Of Payment: ❑ Insurance ❑ Credit Card ❑ Cash

Purpose Of Call _____

Other Family Members In This Practice _____

Whom May We Thank For This Referral? _____

Patient/Parent Social Security Number _____

Spouse/Parent Social Security Number _____

Someone To Notify In Case Of _____

Emergency Not Living With You _____

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Release:

Dental Insurance 1st Coverage

Employee Name _____ Employee Date Of Birth _____

Employer _____

Name Of Insurance Co. _____

Address _____
Street *City* *State* *Zip*

Number of years with company _____ Telephone (_____) _____

Program Or Policy Number _____

Union Locale Group _____

Social Security Number _____

Dental Insurance 2nd Coverage

Employee Name _____ Employee Date Of Birth _____

Employer _____

Name Of Insurance Co. _____

Address _____
Street *City* *State* *Zip*

Number of years with company _____ Telephone (_____) _____

Program Or Policy Number _____

Union Locale Group _____

Social Security Number _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, 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. I understand I am financially responsible for payments in full of all accounts, including collection fees and or attorney fees on delinquent accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's Or Guardian's Signature _____ Date _____