



BEDFORD
DENTAL CARE

REGISTRATION HISTORY

Today's Date: _____

- Male Female
 Single Widowed
 Married Divorced
 Separated
 email address

Patient's Name _____ DOB: _____

Preferred Name _____ SS# _____

Name of Spouse _____

If patient is under 18/Parent's Name _____

Street Address _____

City _____ State _____ Zip _____

Patient Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext. _____ Circle preferred number. E-mail _____

How did you hear about our office? Website Yellow Pages Sign Other Referred By: _____

Patient Employed By: _____ Phone _____

Employer name: _____

If patient under 18, parent employed by: _____ Phone _____

In case of emergency, who should be notified? _____ Phone _____

Do you have Dental insurance that may cover any part of our professional services? Yes No

If so, Primary Dental Insurance _____

SS# / Subscriber ID #: _____ Group #: _____ Subscriber's DOB: _____

Subscriber Name: _____ Subscriber's Employer: _____

Do you have additional Dental insurance? Yes No

If so, Secondary Dental Insurance _____

SS# / Subscriber ID #: _____ Group #: _____ Subscriber's DOB: _____

Subscriber Name: _____ Subscriber's Employer: _____

Delta Dental subscribers only:

I hereby authorize payment of the dental benefits otherwise payable to me directly to *BEDFORD DENTAL CARE*.

SIGNED (EMPLOYEE\SUBSCRIBER)

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE