Patient Registration

Name _____ Date of Birth _____ RacineDentalGroup s.c.
Gender _____ SS # _____
Address _____City _____ State _____ Zip _____
Phone # (Home) _____ Phone # (Work)_____ Email _____
If patient is a minor: Name of mother _____

Name of father _____

Minor resides with: Mother ◯ Father ◯ Both ◯ Other ◯

Person to notify in case of an emergency (other than residence) _____

Relationship _____ Phone # _____

Account Information

Name _____ Date of Birth_____

Relationship _____ Phone # _____

Addresss_____

City _____ State_____ Zip _____

Dental Insurance Information

Primary insurance company _____Employer Name_____

Insured name_____ SS # _____ Date of birth_____

Union/local # _____ Group # _____ Member # _____

Secondary insurance company _____Employer Name _____

Insured name _____ SS # _____ Date of birth_____

Union/local # _____ Group # _____ Member # _____

I, _____, have had full opportunity to read and consider the contents of Racine Dental Group's Accountability Confirmation and Written Financial Policy. I understand that I am entitled to a copy of this consent after I sign it.

_____ _____
Patient, parent or guardian signature Date

_____
Patient name (please print)