Patient Registration

RacineDentalGroup S.C.

Name ______________________________ Date of Birth _______________
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)