PATIENT REGISTRATION INFORMATION

Thank you for choosing the dental office of Maxwell Thaney, DDS, for your dental care. Please complete this form in ink and return it at your appointment. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Name: ______ Date: ______ Birthdate: ______

Address: ______ City: ______ ST/Zip: ______

Home #: ______ Work #: ______ Cell #: ______

Email: ______ SS #: ______

Employer: ______ Occupation: ______

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Spouse or Parent's Name: ______ Workplace: ______

If Student, School Name/Year: ______ City/ST: ______

Emergency Contact: ______ Phone: ______

How did you hear about our practice?

☐ Patient Referral (Name) ______ ☐ Community Health Magazine ☐ Direct Mail/Newsletter ☐ Website

☐ Yelp ☐ Phone Book ☐ Google Ad ☐ Facebook ☐ West Side News ☐ Community Event (Event) ______

RESPONSIBLE PARTY

Name: ______ Relationship to Patient: ______

Address: ______ City: ______ ST/Zip: ______

Employer Name: ______ Birthdate: ______

Home #: ______ Work #: ______ Cell #: ______

SS#: ______ Do you have dental insurance? ☐ Yes ☐ No If yes , complete the information below

INSURANCE INFORMATION

Name of Insured: ______ Relationship to Patient: ______

Birthdate: ______ SS #: ______ Work #: ______

Employer Name: ______ Address: ______

City: ______ State/Zip: ______

Insurance Company: ______ Address: ______

City: ______ State/Zip: ______

Group ID: ______ Policy #: ______

Annual Maximum: ______ % Covered for Cleanings: ______

Annual Deductible: ______ Insurance Company Phone #: ______

SECONDARY INSURANCE INFORMATION

Name of Insured: ______ Relationship to Patient: ______

Birthdate: ______ SS #: ______ Work #: ______

Employer Name: ______ Address: ______

City: ______ State/Zip: ______

Insurance Company: ______ Address: ______

City: ______ State/Zip: ______

Group ID: ______ Policy #: ______

Annual Maximum: ______ % Covered for Cleanings: ______

Annual Deductible: ______ Insurance Company Phone #: ______

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me, if they will allow. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents whether I have dental insurance or not.

Patient or Legal Guardian Signature: ______ *Date:* ______