Treasure Valley DENTAL CARE

PATIENT REGISTRATION

First Name _____ Last Name: _____

Patient is ☐ Policy Holder
☐ Responsible Party

Patient Information

Address: _____ Address 2: _____
City: _____ State/Zip _____
Home Phone: _____ Work Phone: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated
Birth Date: _____ Age: _____ ○ ○ ○ ○
Social Security Number: _____
E-Mail _____ ○ I would like to receive correspondence via e-mail

Who can we thank for your referral?

○ Advertisement _____
○ Location
○ A patient of Treasure Valley Dental Care. If so, who: _____

Emergency Contact: _____
Relation: _____
Phone: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last name: _____
Address: _____ Address 2: _____
City: _____ State/Zip _____
Home Phone: _____ Work Phone: _____ Cellular: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Drivers License Number: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient ○ Self ○ Spouse ○ Child ○ Other
Insured Social Security No. _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____

Authorization

I authorize my insurance company to pay to Treasure Valley Dental Care or its doctors all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that Treasure Valley Dental Care cannot render services on the assumption that any of the charges will be paid by an insurance company. **I understand that I am financially responsible for all charges whether paid by my insurance or not. I understand that if I do not pay my bill, collection action will be taken and I will be responsible for paying any collection and attorney fees. There will be a $50.00 charge for any missed appointments unless 24 hours notice is given prior to missing your appointment.**

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been made.