

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 INFO

Name:		Date:	Birthdate:
Address:		City:	ST/Zip:
Home #:	Work #:	Cell #:	
Email:		SS #:	
Employer:		Occupation:	
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Spouse or Parent's Name:		Workplace:	
If Student, School Name/Year:		City/ST:	
Whom may we thank for referring you to our practice?			
Emergency Contact:		Phone:	

RESPONSIBLE PARTY

Name:		Relationship to Patient:	
Address:		City:	ST/Zip:
Employer Name:		Birthdate:	
Home #:	Work #:	Cell #:	
SS #:	Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 #:		

How did you hear about our practice? Referral Newspaper/Print Ad Website Phone Book
 Other _____

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: _____