PATIENT REGISTRATION

ARIVE a FAMILY DENTAL

CRAIG ARIVE D.D.S.

OWN YOUR SMILE

Date:

Preferred Name:

CONTACT INFORMATION

PLEASE PRINT

First Name: *Middle:* *Last:*

Birthdate: / / *Age:* *Gender:* ❍ Male ❍ Female *Marital Status:* ❍ Married ❍ Single ❍ Widowed ❍ Divorced

Street: *City:* *State:* *Zip:*

Home phone: *Work phone:*

Cell phone: *Email Address:*

Occupation and Employer: *Location:*

How would you prefer to receive your next appointment reminder? (check one)

❍ Mail ❍ Home phone ❍ Work phone ❍ Cell phone ❍ Email

Emergency Contact Name: *Phone:* *Relation:*

INSURANCE INFORMATION

Patient Social Security Number:

Do you have Dental Insurance? ❍ Yes ❍ No

Do you have Secondary Dental Insurance? ❍ Yes ❍ No

Primary Insurance		Secondary Insurance	
Name of Insured:		*Name of Insured:*	
Insured Social Security:		*Insured Social Security:*	
Insured Date of Birth:	/ /	*Insured Date of Birth:*	/ /
Relation to Insured:	❍ *Self* ❍ *Spouse* ❍ *Child* ❍ *Other*	*Relation to Insured:*	❍ *Self* ❍ *Spouse* ❍ *Child* ❍ *Other*
Employer:		*Employer:*	
Employer Phone:		*Employer Phone:*	
Employer Address:		*Employer Address:*	
Insurance Company:		*Insurance Company:*	
Insurance Group No.:		*Insurance Group No.:*	
Insurance Phone:		*Insurance Phone:*	

PLEASE PROVIDE INSURANCE CARD TO BE PHOTOCOPIED

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, dental hygienists, and dental assistants. Failure to provide complete information may result in my receiving a bill for services.

Patient Signature: *Responsible Party Signature:*

BRUSH YOUR SMILE +  FLOSS YOUR SMILE ⇨  OWN YOUR SMILE