Patient Registration

Enlighten Dental

Dr ____ Mr ____ Mrs ____ Ms ____

First Name _____ Last _____ Middle Initial ____ Preferred Name _____

Address _____

City _____ State_____ Zip _____ Home Phone _____

Work Phone_____ Cell _____ E-mail _____

Social Security # _____Date of Birth _____

Referred by_____If full-time student, school name?_____

Dental Insurance

Policy Holder Name _____ Date of Birth _____ Relationship _____

Social Security # _____ Employer _____

Insurance Company Name_____ Group # _____

Insurance Address _____ City _____ State_____ Zip _____

Do you have Secondary Dental Insurance? Yes____No____

Do you receive e-mail correspondence? Yes____No____

Do you receive text messages? Yes____No____

Emergency Contact

Name _____ Relationship _____

Home _____Work_____ Cell _____

I authorize the above individual(s) to be contacted in the event of an emergency.
I understand that treatment information my be discussed for my welfare.

Method of Payment: Cash☐ Check☐ MasterCard☐ Visa☐ Care Credit☐___

Authorization

I authorize payment of any insurance benefits otherwise payable to me, to be paid to the office of Drs. Driscoll , D.D.S., P.A. I authorize the dental office to administer medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my (my child's) dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. When you provide us with a wireless telephone number or land line number you are giving us your prior express consent to call that number.

Signature of Patient/Legal Guardian:_____Date: _____