



PIERSON DENTAL ASSOCIATES
The Builders of Better Smiles

PATIENT'S NAME _____
Last First Initial

Date _____ Date of Birth _____ Male Female

IF CHILD:
PARENT'S NAME _____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED _____

Single Married Separated Divorced Widowed Minor

RESIDENCE - STREET _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

TELEPHONE: RES. _____ BUS. _____

PATIENT/PARENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

SPOUSE/PARENT NAME _____

SPOUSE EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG HELD _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVERS LICENSE NO. _____

METHOD OF PAYMENT: Insurance Credit Card Cash

PURPOSE OF CALL _____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

WHOM MAY WE THANK FOR THIS REFERRAL _____

PATIENT/PARENT SOCIAL SECURITY NO. _____

SPOUSE/PARENT SOCIAL SECURITY NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU _____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE NAME _____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____ # YRS. _____

NAME OF INSURANCE CO. _____

ADDRESS _____

TELEPHONE _____

PROGRAM OR POLICY # _____

UNION LOCAL OR GROUP _____

SOCIAL SECURITY NO. _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to Pierson Dental, L.L.C, otherwise payable to me

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be fully responsible for payment of services not paid, in whole or in part by my dental care payor. In addition, I agree to have a 1.5% service charge added to my account for each of the 30 days payment is past due, excluding insurance.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE: _____

REGISTRATION