



ADULT NEW PATIENT REGISTRATION FORM



Today's Date: _____ / _____ / _____ Name: _____
 Male Female Date of Birth: _____ / _____ / _____ SS#: _____ / _____ / _____ Married Single Other
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 E mail: _____ Patient's Employer: _____ FT
 / PT College Student (College/Univ-Name/Town/State of College): _____
 Who referred you? _____ Phone Book Internet Refer a Friend
 Emergency Contact: Name: _____ Relationship: _____
 H phone: _____ W phone: _____ Cell phone: _____

PRIMARY DENTAL INSURANCE

Primary Insurance Company: _____
 Primary Policyholder-Subscriber Name: _____
 Address: _____ **WE CAN PHOTOCOPY YOUR CARD**
 Home Ph#: _____ Work Ph# _____ Cell Ph# _____
 DOB: _____ / _____ / _____ SS#: _____ / _____ / _____ Group#: _____ ID#: _____
 Employer: _____

SECONDARY DENTAL INSURANCE

Secondary Insurance Company: _____
 Secondary Policyholder-Subscriber Name: _____
 Address: _____ **WE CAN PHOTOCOPY YOUR CARD**
 Home Ph# _____ Work Ph#: _____ Cell Ph#: _____
 DOB: _____ / _____ / _____ SS#: _____ / _____ / _____ Group#: _____ ID#: _____
 Employer: _____

ADULT CONSENT FOR TREATMENT:

I certify that the information that I have provided on this form is complete and accurate to the best of my knowledge. I understand that providing accurate information regarding my health allows Brink Street Dental, Ltd. to treat me effectively and safely. I understand that I am financially responsible for all charges whether they are covered by insurance or not. I authorize the clinical staff of Brink Street Dental, Ltd to perform necessary diagnostic dental services including, but not limited to x-rays, intraoral photographs and diagnostic models. I understand that I will be consulted as to all recommended treatment and alternatives before treatment is provided.

X _____ **X** _____
 Date: _____ Signature of Insured: _____

ASSIGNMENT OF BENEFITS TO INSURANCE:

I, the undersigned, have dental insurance coverage and request assignment of benefits to Dr. David Niles of Brink Street Dental, Ltd. I understand that the information given will be held in strict confidence. I hereby authorize the doctor to release all information necessary to secure the payment of benefits unless revoked. I authorize the signature on all insurance submission whether manual or electronic:

X _____ **X** _____
 Date: _____ Signature of Insured: _____