Roadt Family Dental

Patient's Name _____ Date of Birth _____ Male ☐ Female ☐

Nickname _____ Parent's / Guardian's Name _____

Address _____ City _____ Zip_____

Home phone _____ Alternate phone _____

Other family members in this practice _____ Purpose of call_____

Parent employed by _____ Whom may we thank for this referral_____

Dental insurance company _____Person responsible for account _____

Responsible Party's SSN _____ DOB _____

I authorize payment directly to the dentist or dental group of insurance benefits 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, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be liable for payment of services not paid, by my dental care payor.

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

PATIENT'S / GUARDIAN'S SIGNATURE_____ Date _____

# CHILDREN'S REGISTRATION