TRU Dental, PC **REGISTRATION**

Patient's full name: Date of Birth: ☐ Male ☐ Female

If Minor: Parent's Full Name:

How do you wish to be addressed? Referred by:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence address: City, State, Zip:

Phone #1: Phone #2:

Business address: City, State, Zip:

Phone #1:

Email:

Patient **or** Parent employer:

Spouse name:

Who is responsible for this account?

Driver's License State: Driver's License Number:

Name & phone of someone (not living w/you) to notify in case of emergency:

DENTAL INSURANCE - PRIMARY		**DENTAL INSURANCE – SECONDARY**	
Policy Holder name:		Policy Holder name:	
Policy Holder date of birth:		Policy Holder date of birth:	
Social Security #		Social Security #	
Employer name:		Employer name:	
Insurance Co:		Insurance Co:	
Address:		Address:	
City, State, Zip:	Phone:	City, State, Zip:	Phone:
Policy #	Group #	Policy #	Group #

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care:

1.
2.

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and 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 responsible for payment of services not paid by my dental care payer.

I attest to the accuracy of the information on this page

PATIENT OR GUARDIAN'S INITIALS: **DATE:**

I UNDERSTAND ALL APPOINTMENTS ARE CONSIDERED CONFIRMED WHEN SCHEDULED AND TO AVOID A MISSED APPOINTMENT FEE ($25/HALF-HOUR), A MINIMUM OF 24 HOURS NOTICE IS REQUIRED IF I'M UNABLE TO KEEP APPOINTMENT.

PATIENT OR GUARDIAN'S INITIALS: **DATE:**

I understand TRU Dental PC posts a copy of their Privacy Practices in their lobby. I also understand I may obtain a copy of TRU Dental,PCs Privacy Practices via:

1. TRU Dental's website: trudentalnm.com
2. Request a copy from TRU Dental's front office

PATIENT OR GUARDIAN'S INITIALS: **DATE:**

F003.2

SUBMIT