# Welcome to

## Fox Valley Dental Care

**Patient Registration** (Confidential)

Patient Name:_____ Date:_____

Address:_____ City:_____ Zip:_____

Home Phone # :_____ Cell Phone #:_____

Birthday:_____ Patient Social Security #_____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Separated

Person Responsible For Account (Guarantor):_____

Employer: _____Work Phone: _____

e-mail address:_____(confidential)

Guarantor Social Security Number: _____-_____-_____

Guarantor Drivers License Numer: _____-_____-_____

Emergency Contact (person not living at same address):

Name:_____ Phone: _____

**Insurance Information**

| Primary Insurance (Employee) | Secondary Insurance (Spouse) |
|---|---|
| Subscriber:_____ | Subscriber: _____ |
| Insurance Company: _____ | Insurance Company: _____ |
| Ins. Company Phone #:_____ | Ins. Company Phone #:_____ |
| Social Security #: _____ | Social Security #: _____ |
| Birthday: _____ | Birthday:_____ |
| Group #:_____ | Group #:_____ |

❑ I authorize payments of dental benefits to the named provider for professional services rendered.

❑ I authorize the release of any dental information necessary to process the claim.

❑ I hereby authorize Fox Valley Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature: _____