



# Welcome to

## Fox Valley Dental Care

### Patient Registration (Confidential)

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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)

Subscriber: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Ins. Company Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Birthday: \_\_\_\_\_

Group #: \_\_\_\_\_

#### Secondary Insurance (Spouse)

Subscriber: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Ins. Company Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Birthday: \_\_\_\_\_

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: \_\_\_\_\_