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: _____