Registration

Robert E. Tanner, DDS

Welcome to our office

Name: _____ **M** ___ **F** ___ Birthdate:_____
Last First MI

Address:_____ City:_____State:____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Email:_____Employer:_____
SSN:_____ Marital Status:____ Name of Spouse:_____
If a child, parent's name:_____
Contact in case of emergency: Name:_____ Phone:_____
Previous dentist and phone#:_____
Whom may we thank for referring your family?_____

Person responsible for account:

Name:_____
Address:_____ City:_____State:____ Zip:_____
Home Phone:_____ Work Phone:_____
SSN:_____ Birthdate:_____
Employer:_____City:_____

Primary Insurance Coverage (Dental):

Subscriber Name:_____
SSN:_____ Birthdate:_____
Employer:_____City:_____
Insurance Name:_____
Address:_____
Phone:_____
Group ID#:_____Subscriber ID#_____

Secondary Insurance Coverage (Dental):

Subscriber Name:_____
SSN:_____ Birthdate:_____
Employer:_____City:_____
Insurance Name:_____
Address:_____
Phone:_____
Group ID#:_____Subscriber ID#:_____

I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. If the patient does not have dental insurance, the payment is due at the time of service. The guardian who brings in a child, or who the child lives with, is ultimately responsible for all unpaid balances. I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. Please note, as a courtesy to our staff and other patients please allow at least 24 hours to cancel or reschedule an appointment.

Signature:_____ Today's Date:_____ **~ OVER PLEASE ~**