Fink Dental Center Patient Registration

Date ___________ Date of Birth ___-___-_____

Patient Name ____ Nickname _________________ M ☐ F ☐
First MI Last

Address ____ Zip Code _____________

Home # (____) ____-_____ Cell # (____) ____-_____ Email ____

Employer __________________________ Work # (____) ____-_____ Job Title _______________ Years ____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ☐

Spouse ______________________________ Employer _____________________ Work # (____) ____-_____

Guardian _________________________ ________________ # (____) ____-_____ __________________
Name Relationship Phone Employer

Guardian _________________________ ________________ # (____) ____-_____ __________________
Name Relationship Phone Employer

Emergency Contact ___________________________ _________________________ # (____) ____-_____
Name Relationship Phone

Who can we thank for referring you to our office?: ____

Dentist ____________________________________ Physician __________________________________

Account Holder (if different than patient) _____________________________ ________________________
Name Relationship to Patient

Address ____ Zip Code _____________

(____) ____-_____ C#(___)____-_____ SS# _____ - _____ - _____ Birth Date ____-____-____
Phone

Primary Ins. Co. ______________________________ Employer _________________ Group # __________

Subscriber __________________________________ DOB ____ - ____ - ____ SS#/ID# __________________

Secondary Ins. Co. ____________________________ Employer _________________ Group # __________

Subscriber __________________________________ DOB ____ - ____ - ____ SS#/ID# __________________

Payment is due in full at the time of treatment unless other financial arrangements have been approved. A finance charge will be added to balances more than 30 days past due. I am fully responsible for total payments to Dr. Richard L. Fink including any amounts which are not covered by my dental insurance. Should legal action be necessary to collect this account, I agree to pay all expenses incurred to Dr. Fink. I assign directly to Dr. Fink all benefits, otherwise payable to me for services rendered. I authorized Dr. Fink to release all information necessary to secure the payment of benefits. I authorized the use of the signature on all insurance submissions. I hereby authorize and request the performance of dental services and I give consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Fink or his staff for diagnostic purposes or dental treatment.

____ ____________________ _____________ __________
Signature (If under 18, Parent/Guardian) Relationship Date Staff Initials