



## REGISTRATION FORM – PLEASE PRINT

Today's date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: (    )		
Please help us understand why you chose Canyon Vista Dental Care today (please check all that apply):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Internet
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	
Other family members seen here:							
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: (    )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: (    )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Delta Dental	<input type="checkbox"/> Cigna		<input type="checkbox"/> DMBA	<input type="checkbox"/> Dental Select	<input type="checkbox"/> Aetna
<input type="checkbox"/> Met Life	<input type="checkbox"/> Unicare		<input type="checkbox"/> Ameritas		<input type="checkbox"/> United Concordia		<input type="checkbox"/> Other
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: (    )	Work phone no.: (    )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.							
<i>Patient/Guardian signature</i>						<i>Date</i>	