WELCOME NEW PATIENT TO
Flannigan Family Dentistry, LLC
REGISTRATION

☐ MALE
☐ FEMALE

Patient's Name: ____ ___/___/___
Last First Date of Birth

If patient is a child, Parent or Guardian's Name: ______________________________ ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced ☐ Minor

Residence: Address City State Zip

Business: Address City State Zip

Home Phone:__________ Business Phone:__________ Cell Phone: __________ FAX: __________

eMail address: ______________________________

Patient/Parent Employed by:______________________ Current Position: __________ How Long: _____

Spouse Employed by: ______________________Current Position: __________How Long: _____

Who is Responsible for this Account?__________________ Driver's License # __________Issuing State:_____

Service Needed: __________________ By whom were you referred to us? __________________

Indicate other family members who are Patients of Flannigan Family Dentistry: __________________

Method of payment for this visit: ☐ Cash ☐ Credit Card ☐ Insurance

Patient/Parent Social Security # ____/____/____ Spouse/Parent Social Security # ____/____/____

Emergency Contact: (Someone not living with you) __________ Relationship __________ Phone __________

PRIMARY DENTAL INSURANCE

Policy Holder's Name ______________________

Relationship to Patient:______________________

Employer:______________________ Years ______

Insurance Company: ______________________

Address:______________________

Telephone: ______________________

Policy Number:______________________

Group Number: ______________________

Policy Holder Social Security: ______________________

SECONDARY DENTAL INSURANCE

Policy Holder's Name ______________________

Relationship to Patient:______________________

Employer:______________________ Years ______

Insurance Company: ______________________

Address:______________________

Telephone: ______________________

Policy Number:______________________

Group Number: ______________________

Policy Holder Social Security: ______________________

CONSENT FORM:

I hereby consent to the diagnostic procedures by a Flannigan Dental Professional, and any treatment necessary for proper dental care. I also consent to Flannigan Family Dentistry's use and disclosure of my records, or those of my child, to fascilitate treatment, to collect an unpaid account balance, and for those activities and health care operations that are related to treatment or payment. I also consent to the disclosure of my records or those of my child to the following persons who are involved in the care of me or my child for the payment for that care:

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My consent to disclosure of records shall be effective until I revoke it in writing. I also do hereby authorize payment directly to Flannigan Family Dentistry of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual services billed, and that I am financially responsible for the remainder of payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. I also do hereby attest to the accuracy of the information on this page.

______________________________________ Date: ______________

PATIENT'S OR GUARDIAN'S SIGNATURE

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