Michael D. Vanover, D.D.S., P.A.

Family & Cosmetic Dentistry For All Ages

Patient Registration – Welcome to Our Office

About You

Today's Date: ________________________________

Name: ______________________________________

Last First M. Dr. Mr. Mrs. Ms. Rev.

I prefer to be called: ______________ ☐Male ☐Female

Birthday: ___/___/______ Age: ____

SS#: _____-____-_______

Home Address: ______________________________

______________________________Zip: ___________

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: ______________ Cell #: _______________

E-mail: _____________________________________

Work #: __________________ Ext: ______

Employer: ___________________________________

How Long There? _____ Occupation: ____________

Who may we thank for referring you?

____

Other family members seen by us:

____

Previous/Present Dentist: _______________________

Last Visit Date: ______________________________

What is your primary concern or reason for this appointment? ________________________________

____

Your Contact Preferences

Best way to be reached: (Please circle all that apply)

Home Ph | Work Ph | Cell Ph | Email | Text Message

Best way to be reminded of appointments:

Home Ph | Work Ph | Cell Ph | Email | Text Message

We do NOT share patient information with any other sources.

Dental Insurance

Insurance Co Name: _________________________

Insur. Co Phone#: __________________________

Policy Holder's (Subscriber) Information

Subscriber's Name: _________________________

Member/Subscriber's ID #:____________________

Subscriber's SS#: _______ - ______ - __________

Subscriber's DOB: ____/____/_____

Subscriber's Relation to Patient: _______________

Subscriber's Employer: ______________________

Spouse Information

Spouse's Name: _____________________________

Employer: _________________________________

Work #: ___________________ Ext: ______

Birthday: ___/___/______ Age: ____

SS#: _____-____-_______

Medical Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name: ____________________________________

Relation to you: _____________________________

Work#: ______________ Home#: ______________

Cell #: ____________________________________

I understand that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in strict confidence and that it is my responsibility to inform office of any changes in insurance, and/or medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

I understand that payment for all treatment is ultimately my responsibility regardless of insurance coverage. I authorize the release of any information required to process my dental insurance and payment to be sent directly to this office. If this account is sent to collections, I agree to pay all associated costs incurred. Payment is due in full at time of treatment unless prior arrangements have been approved.

X ____

Signature Date