Hayden Family Dental Center, PLLC

Benjamin D. Babcock, DDS
52 W. Commerce Drive - P.O. Box 7
Hayden, ID 83835
(208) 772-3132

Rev. 8/01/11

Patient Registration Information

Welcome to our practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Date__________________ Email Address_____________________________________

Name____Preferred/Nick Name____________________

Date of Birth___________________________Social Security #________________________________

Address__________________________________City______________State________Zip___________

Cell Phone____________________Home Phone_________________Work Phone_______________

Male____ Female____ Minor____Single____Married____Divorced____Widowed____Separated____

Employer___________________________________Occupation________________________________

Employer's Address______________________________Referred By__________________________

Closest Relative other than Spouse__________________Relationship__________Phone__________

♥♥

Spouse

Name of Spouse______________________________Social Security #__________________________

Spouse's Date of Birth_____________Spouse's Employer_______________Occupation___________

♥♥

Responsible for Account

Name____Relationship to Patient____________________

Address (if different)_____________________________City______________State______Zip________

Phone # __________________________________Social Security #______________________________

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Insurance Information

Name of Insured___________________________________Relationship to Patient_________________

Insurance Company_________________________Group #____________Subscriber #_____________

Date of Birth_____________________Insurance Company Phone #____________________________

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Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

I understand that the information I have given today is correct to the best of my knowledge.

X____ ________________________________
Signature of patient or parent/guardian if minor Date