Spark Dental
FOR KIDS AND ADULTS

PATIENT REGISTRATION

Welcome! *Please complete the following confidential information*

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

SOCIAL SECURITY # _____ DATE OF BIRTH _____

EMAIL ID _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER: _____ WORK PHONE _____EXT_____

HOME PHONE _____ CELL PHONE _____

RELATIONSHIP TO INSURANCE SUBSCRIBER (The person in your family who your insurance is through): Self Spouse Child Other

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

DATE OF BIRTH _____ MARITAL STATUS: Married Single Other WORK PHONE _____EXT_____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ GROUP/POLICY # _____

NAME OF SUBSCRIBER _____ SOCIAL SECURITY # _____
(First) (Middle) (Last)

DATE OF BIRTH _____ MARITAL STATUS: Married Single Other WORK PHONE _____ EXT_____

EMPLOYER _____ FULL-TIME OR PART-TIME EMPLOYEE (Circle One)

HOW DID YOU HEAR ABOUT US : _____

CONSENT:

1. I hereby authorize Spark Dental staff to take X-rays, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I consent to the use of appropriate medication and therapy as deemed necessary. I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment not evident during Initial examination.

2. **I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Spark Dental. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.**

3. By signing below, **I certify that I read and write English and I have read, fully understand, and agree to the above items**.

Patient/Parent/Guardian's Signature _____ **Date** _____