COMMUNITY DENTAL HEALTH

1436 N. Hancock Avenue
Colorado Springs, CO 80903
(719) 310-3315

## PATIENT REGISTRATION

Date: _____

Name: _____ Preferred Name: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Date of Birth: _____ Married: ☐ Yes ☐ No

☐ Male ☐ Female ☐ Other

Email: _____

How did you year about us? _____

**Emergency Contact:**

_____
Name

_____
Phone

## RESPONSIBLE PARTY (If other than patient)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

## INSURANCE INFORMATION (Please provide insurance card)

**Primary Dental Insurance Company:** _____ Employer: _____

Subscriber: _____ DOB _____ ID# _____ Group #_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Domestic Partner **SOCIAL SECURITY #**_____

**Secondary Dental Insurance Company:** _____ Employer: _____

Subscriber: _____ DOB _____ ID# _____ Group #_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Domestic Partner

**ASSIGNMENT OF DENTAL BENEFITS.** I authorize Community Dental Health to furnish information to my insurance carrier concerning treatment and I assign all insurance payments to this office for dental services rendered to myself or dependents.

**SIGNATURE OF PATIENT, PARENT OR GUARDIAN** _____ **Date:** _____

I agree to receive electronic communication from Community Dental Health (i.e.: emails, receipts) ☐ Yes ☐ No
I have received a review copy of this office's notice of Privacy Practices. *You may refuse to sign this acknowledgement*
SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ Date: _____