Dale E. Kasting, D.M.D.

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REGISTRATION

Patient's Name _____Spouse Name_____
Prefers to be addressed by _____ Date of Birth _____ Age _____
If patient is a child, Mother's & Father's names _____
_____
Patient's Marital Status: Single_____ Married_____ Divorced____ Widowed_____ Minor_____
Patient's Residence_____
Street Address City State Zip
Patient's Home # _____ **Patient's** Cell #_____
Mother's and Father's address (if different from patient)_____
_____
Patient/Parent Employer _____ Work #_____
Spouse Employer _____ Work # _____ Cell #_____
Who is responsible for this account _____
Major method of payment is: Insurance ____, Credit Card ____, Cash or Check ____.
Purpose of visit _____
Family members already in this practice _____
How did you hear of our practice, or name of person referring you _____
If patient is a child, Mother's Social Security Number _____-_____-_____
Father's Social Security Number _____-_____-_____
Adult patient Social Security Number _____-_____-_____
Spouse's Social Security Number _____-_____-_____
Someone to notify in case of an emergency _____@_____

PRIMARY DENTAL INSURANCE

Employee Name _____
Employee Date of Birth _____
Employee Soc. Sec. # _____-___-_____
Employer Name _____
Name of Insurance Co. _____
Insurance Address _____
_____
Telephone Number _____
Program or Policy Number _____
Union Local or Group Number _____

SECONDARY DENTAL INSURANCE

Employee Name _____
Employee Date of Birth _____
Employee Soc. Sec.# _____-___-_____
Employer Name _____
Name of Insurance Co._____
Insurance Address_____
_____
Telephone Number _____
Program or Policy Number_____
Union Local or Group Number _____

I attest that the information provided on this page is accurate. I understand the patient is responsible for all fees incurred unto this account. Any underpayment by insurance companies is an issue between the patient, the patient's insurance company, and the patient's employer. This office files insurance forms for our patients at no fee, however, we make no guarantees on behalf of your insurance company. **Any fees not paid by insurance are the responsibility of the patient.**

Patient's or Guardian's Signature_____Date_____
