Integrity Dental Care
Richard Treharne, DDS
David Kelley, DDS
Danielle Gulis, DMD

Patient Registration

Patient Information

First Name:	Last Name:	M.I:	Sex: ☐ Male ☐ Female
Mailing Address:	City/State/Zip:		
Social Security #:	Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced	
Home Phone:	Cell Phone:	Work Phone w/ Ext:	
Where may we leave a detailed Voicemail (choose one) ☐ Home ☐ Cell ☐ Work ☐ None			
Email Address: ____ What may we use email communication for? ☐ Appointment reminders, if unable to be reached by text messaging ☐ News & Events ☐ Financial Communication			
Emergency Contact:	Phone Number:	Relationship to Patient:	

Insurance & Payment Information

Responsible Party **(receives statements):** Name:		
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:	City/State/Zip:	

Primary Insurance Company:	Secondary Insurance Company:
Employer of Policy Holder:	Employer of Policy Holder:
Group #:	Group #:
Subscriber ID #:	Subscriber ID #:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Address if not same:	Policy Holder's Address if not same:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Responsible party please initial each line item and sign below

________ RECORDS RELEASE: I authorize Integrity Dental Care to release medical records and billing information to referring specialists when necessary.

________ FINANCIAL AGREEMENT: I clearly understand that the fees of this office are set by this office and not bound by my insurance company's fee schedule, the financial responsibility of payment for dental services provided is mine and that payment is due at the time of services rendered. Furthermore, I understand that having insurance is not a guarantee of payment to Integrity Dental Care.

________ I understand that if I miss a scheduled appointment or give less than a 24 hour notice of canceling an appointment I will be charged $50.00

Signature of Patient/Legal Guardian:____ Date:____________________