

WELCOME to RENKEN Dentistry

We would like to take this opportunity to welcome you and thank you for joining our dental practice. We appreciate your confidence in us and will do everything possible to provide you with the finest dental care. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient's Name _____

Date of Birth _____

Social Security Number _____

Driver's License Number _____

How Do You Wish To Be Addressed _____

Single__ Married__ Divorced__ Widowed__ Minor__

Residence—Street _____

City _____ State _____ Zip _____

Telephone _____

Best Time to call _____

E-mail _____

Employer _____

Business Address _____

Business Telephone _____

Can we contact you at work? Yes ___ No ___

Spouse's Name _____

Other Family Members With This Practice

Who is responsible for this account _____

Whom may we thank for your referral _____

In the event of an emergency, is there someone who we can

contact? Name _____

Relationship _____

Telephone number _____

(IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST COMPLETE THE INFORMATION BELOW)

Parent's Name _____

Date of Birth _____

Social Security Number _____

Driver's License Number _____

Residence & Phone Number (if different from
child) _____

Method of payment:

- Insurance (**However, I am responsible for any deductible/estimated co-pay at the time of service**)
- Payment in full** at each appointment (cash or personal check)
- Payment in full** at each appointment (Visa, MC, Discover, Care Credit)
- I wish to discuss the Dental Office's Financial Policy (Please see our Office Policies form included with your packet for additional information)

Dental Insurance Primary Coverage

Primary Subscriber's Name _____

Date of Birth _____

Social Security # _____

Employer _____

Name of insurance co. _____

Address _____

Telephone _____

Policy or Group # _____

Union or Local Group _____

Dental Insurance Secondary Coverage

Secondary Subscriber's Name _____

Date of Birth _____

Social Security # _____

Employer _____

Name of insurance co. _____

Address _____

Telephone _____

Policy or Group # _____

Union or Local Group _____