ADULT REGISTRATION

(Patients 18 years of age and older)

Snyder Dentistry

Kelly Anne Snyder, DDS, P.C.

4488 Holt Rd.
Holt, MI 48842
517-694-4700

Welcome to our practice! We would like to sincerely thank you for selecting our team, and we look forward to the opportunity to provide you with quality and comfortable dental care.

PATIENT INFORMATION

First Name______________________ Last Name______________________ MI______ M / F

Social Security #______________________ Birth Date______________ Preferred Name______________

Address____

Employer______________________________ Occupation______________________________

Home Phone__________________ Cell Phone__________________ Work Phone__________________

Email______________________________ *may we send email correspondence regarding appointments?* YES NO

Preferred Method of Contact *(please circle at least one)*: Home Work Cell Email

Marital Status (*please circle*): Single Married Separated Divorced Widowed

In the event of an emergency, whom should we contact?

Name____________________________ Relationship____________________ Phone #______________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

Insured's Name__________________________ Relation____________ Insured's Birth Date____________

Insured's Social Security #____________________ Insured's Employer______________________________

Insurance Group #________________________ Insurance Policy #______________________________

Insurance Company Name__________________________ Insurance Company Phone #__________________

SECONDARY DENTAL INSURANCE:

Insured's Name__________________________ Relation____________ Insured's Birth Date____________

Insured's Social Security #____________________ Insured's Employer______________________________

Insurance Group #________________________ Insurance Policy #______________________________

Insurance Company Name__________________________ Insurance Company Phone #__________________

AUTHORIZATION AND RELEASE

I authorize the dentist / staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent. I authorize the dentist / staff to release any information including diagnosis and records of any treatment or examination rendered to third party payers and/or health practitioners. I authorize and request my dental company to pay directly to the dentist any insurance benefit otherwise payable to me. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for myself or dependents. I understand that payment is due at the time of service unless other arrangements have been made.

____ ________________________

PATIENT SIGNATURE **DATE**