

ADULT REGISTRATION

(Patients 18 years of age and older)

Snyder Dentistry

Kelly Anne Snyder, DDS, P.C.

2101 N. Aurelius Rd.
Suite 3
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