edinadentalcare
COMPREHENSIVE AND AESTHETIC DENTAL CARE

Registration Form - Adult

Patient Name: _____ Preferred Name: _____

Birthdate: _____ Gender ☐ Male ☐ Female

Pronouns: ☐ She/her ☐ He/him ☐ They/them ☐ Other _____

Address _____

City / State/ Zip _____

Phone Number _____ Secondary Phone _____

Email: _____

Do you give Edina Dental Care permission to share your medical and dental information? ☐ Yes ☐ No

If yes, please list their name, relationship to you, and phone number

_____

FINANCIAL INFORMATION

Person Financially Responsible for Account _____

Relationship to Patient _____

Complete if the patient is not financially responsible for their account.

Billing Address _____

City / State / Zip _____

Guarantor Phone Number _____

Guarantor Email _____

DENTAL BENEFIT PLAN INFORMATION

Insurace Company Name _____ Employer _____

Address _____ City / State / Zip _____

Name of Policyholder _____ Member ID _____

Policyholder Birthdate _____ Group Number _____

Patient Relationship ☐ Self ☐ Spouse / Partner ☐ Child ☐ Other _____

*If the dental benefit card does not have a member ID it is most likely the policyholder's social security number.

How did you hear about us? _____

I authorize the administration of such medications and performance of such diagnostic and therapeutic procedure as may be necessary for proper dental care. If information for purposes of treatment or payment is needed, I authorize Edina Dental Care to contact the appropriate health care provider or agency to obtain such information, and authorize Edina Dental Care and such health care provider or agency to release information to each other for such purposes.

Payment is due at the time of service unless prior arrangements have been made. I understand that I am responsible for all dental services provided to me.

I agree that I am personally responsible for payment of fees for services not covered in whole or in part for any insurance carrier. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the deb, including fees charged by a collection agency.

I agree to notify Edina Dental Care if any of the information on this registration for changes.

_____

Signature of patient, guardian, or legal representative Date: