The Offices of Fredrick M. Vega, D.D.S., P.C. & Associates

PATIENT REGISTRATION FORM

This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give you the personal attention you deserve. This information is completely confidential. Thank you.

Last Name________________________________ First Name______________________ Middle Initial_____

Address__________________________________ City_________________ State_____ Zip Code_________

Home Phone____________________ Cell Phone___________________ Work Phone___________________

Marital Status__________ DOB__________ SS #________________ Drivers License___________________

E-mail____ ☐ I would like to receive correspondences via e-mail

Employer____ Work Phone___________________

Employer's Address____

Are you experiencing any dental problems at this time? If so, what?_____________________________________

Last dentist visit?____________ What was done then?____________ How did you hear about us?_____________

Please list others authorized to discuss your dental account ____
including: ☐ dental ☐ financial

In order to obtain maximum dental benefits for our insured patients, we have our staff specifically trained to do just that. In order to get your full complete benefits, we will need the following:

Primary Insurance Information: Name of Insurance Company____

Address____ Phone Number___________________

Name of Insured_____________________________________ SS #__________________ DOB____________

Employer Name, Address & Phone____

Policy Number__________________ Group Number_______________ Name of Insured_________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________________

Secondary Insurance Information: Name of Insurance Company_______________________________________

Address____ Phone Number___________________

Name of Insured_____________________________________ SS #__________________ DOB____________

Employer Name, Address & Phone____

Policy Number__________________ Group Number_______________ Name of Insured_________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________________

I hereby authorize and request the performance of dental services for myself by Dr. Fredrick Vega and staff. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Vega and staff for diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage.

____ _______________________
(Signature) (Date)