PAUL A. KLOEK, DDS
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PATIENT REGISTRATION

Patient Information

Name:____ (_______________) ☐ New Patient ☐ Update

First Last preferred name

☐ Male ☐ Female ☐ Student ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Date of Birth: _________/________/__________ **Patient Social Security #:** _______-______-_______

Address:____ ________________________

Mailing Address Home #

____ ________________________

Physical Address (if different) Cell #

____ ________________________

City State Zip Code Work# EXT

Email:____

*IF CHILD, PROVIDE PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name(s):______________________________Date of Birth:_____/______/_____ SS#______________

Whom may we thank for referring you?____

Employment Information (If minor, Parent/Guardian Information)

Are you currently employed? ☐ Yes ☐ No Employer: ________________________ Occupation: _______________

Employer Address/Phone #: ____

Dental Insurance Information

Primary Dental Insurance

Policy Holder Name______________________________

Policy Holder ID or SS# __________________________

Date of Birth____________________________________

Relationship to Policy Holder ☐Self ☐Spouse ☐ Child ☐Other

Employer Name (of Policy Holder)__________________

Insurance Company______________________________

Insurance Group # ______________________________

Secondary Dental Insurance

Policy Holder Name______________________________

Policy Holder ID or SS# __________________________

Date of Birth____________________________________

Relationship to Policy Holder ☐Self ☐Spouse ☐ Child ☐Other

Employer Name (of Policy Holder)__________________

Insurance Company______________________________

Insurance Group # ______________________________

Emergency Contact

In case of emergency, please provide information for the nearest relative or designated contact person.

____ _________________

Name Relationship Phone #

Authorization/Consent:

I certify that the above information is true and correct to the best of my knowledge. I agree to notify Green Valley Dental Care of any changes in the above information and/or my insurance/health status.

I consent to the diagnostic procedures and dental treatment performed by the dentist and to the release of information concerning my (or my child's) dental/health care, advice, and treatment to another dentist or for evaluating and administering any claims for insurance benefits. My consent to disclosure of records shall be effective until I revoke it in writing. I consent to the direct payment of my insurance benefits to Green Valley Dental Care and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

Consent for Care of Minors (age 17 and younger) (if applicable)

I consent to the examination and/or treatment of the minor child named above.

In my absence I hereby authorize _____________________________ (Name/Relationship of adult accompanying child to office) to accompany the above-named minor to dental visits at Green Valley Dental Care, and to consent to the examination and/or treatment of above named minor, during the visits.

I authorize the minor child named above to come alone to dental visits at Green Valley Dental Care

Patient/Guardian Signature: ___________________________________ **Date:** ____________