…CONFIDENTIAL…

Park Cities
PERIODONTICS & IMPLANT DENTISTRY
BETH TOMLIN, DDS, MS

Patient Registration Information

WELCOME TO OUR PRACTICE!
THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM.

Please fill out this form completely in ink. If you have any questions, please do not hesitate to ask for assistance. We will be happy to help.

DATE _____ **WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** _____

WHO IS YOUR GENERAL DENTIST? _____ **PHONE #** _____

Emergency Contact (name and phone #): _____

Patient Name _____
First Last MI Nickname

Date of Birth _____ SS# _____-_____-_____ Marital Status: _____

Address_____ City_____ State_____ Zip_____

PHONES: Home _____ Work _____ Cell _____ Text Message OK? Yes / No

E-Mail Address: _____ Preferences: Home / Work / Cell / E-Mail

DENTAL INSURANCE INFORMATION: Insurance Company _____Phone_____

Primary Insured: Name _____ SS#_____ Birthdate _____

Relationship to patient_____ Employer_____

Employer Address _____ City _____ State _____ Zip _____

RELEASE: I understand that accurate and complete diagnosis is an essential first step in my dental care and authorize Dr. Beth M. Tomlin to perform diagnostic procedures as may be necessary to achieve an accurate and complete diagnosis. I also understand that effective diagnosis and treatment may necessitate the involvement of other health professionals in my care and therefore authorize release of any information concerning my (or my child's) health care, advise, and treatment to another dentist or physician. While I understand that I am ultimately responsible for all dental treatment fees, I would appreciate the office's assistance in submitting to my insurance company for reimbursement. I authorize release of any information concerning my (or my child's) health care, advice or treatment provided for the purpose of evaluating and administering claims for insurance benefits and securing payment for treatment. I authorize payment of insurance benefits be made directly to Dr. Beth M. Tomlin. A fee of $35 will be owed by patient for any check dishonored by recipient's bank account.

_____ _____
Signature of patient (or Parent/Guardian if minor) **Date**

Please tell us what is important to you in visiting a periodontist: _____

What can we do to make your appointment more enjoyable? _____

What kind of music do you prefer? _____

Do we have your permission to use your testimonial, photos, and name to let other patients know about your experience with our office? _____Yes _____No _____
Signature

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.