Todd Blincoe, D.M.D.
Jennifer Kramer Blincoe, D.M.D.

Family Dentristy

Adult's Registration Form

*Patient's name:*_____
(first) (m.i.) (last)

*Address:*_____

*City:*_____ *State*_____ *Zip*_____

*Home Phone:*_____ *Cell Phone:*_____

*Marital Status:*_____ *S.S.#:*_____ *Birth Date:*_____

*Occupation:*_____ *Employer:*_____

Business Address: _____ *Bus. Phone:*_____

*Spouse's Name:*_____*Cell Phone:*_____
(first) (m.i.) (last)

*S.S.#:*_____ *Birth Date:*_____

*Occupation:*_____ *Employer:*_____

Business Address: _____ *Bus. Phone:*_____

Do you have dental insurance? yes_____ no_____

*Insurance Company:*_____ *Group Name:*_____

Does your spouse have dental insurance? yes_____ no_____

*Insurance Company:*_____ *Group Name:*_____

Preferred method of payment: cash_____ check_____

*Whom may we thank for referring you to our office?*_____

I authorize the release of any information relating to my condition or treatment procedures for use in filing a claim for benefits with my insurance company, and I authorize any payment of insurance benefits directly to Dr. Blincoe. I understand that I am responsible for payment of services rendered regardless of payment made by my insurance company.

Signed_____