Dental Care Associates of Buffalo, P.A.

Registration Form

Patient Information
Please fill out all information below as completely as possible.

Date:
Name Preferred Name:
Gender: ☐ Male ☐ Female Birthdate: Married? ☐ Yes ☐ No
E-mail: Cell Phone: Home Phone: Work Phone:
Street Address: City State:
Zip: Social Security #: Guardian's name if patient is a minor:
Student status if dependent over 19 (for insurance): ☐ Fulltime ☐ Parttime ☐ Non-student
Whom may we thank for referring you to our office? Referral email:

Responsible Party Information

Name
Street Address: City State: Zip:

Dental Insurance Information

Policyholder's Name: Social Security #: Birthdate:
Relation to patient: Employer Name:
Insurance Company: Group #: Local #:
Insurance Co. Address: City State: Zip:
Are you covered by another dental plan? ☐ Yes ☐ No If Yes, which one?
Policyholder's Name: Social Security #: Birthdate:
Relation to patient: Employer Name:
Insurance Company: Group #: Local #:
Insurance Co. Address: City State: Zip:

PLEASE BRING PHOTO ID. AND INSURANCE CARD TO YOUR APPOINTMENT

I have received, reviewed and understand the financial policy of Dental Care Associates of Buffalo. I also understand, that where appropiate, credit bureau reports may be obtained. Although we try to estimate insurance benefits as best we can when applicable, we can in no way guarantee coverage. If you have any questions, please contact your insurance company.

Indicate by placing a X in the box next to YES if you agree and accept the financial agreement.

☐ Yes