WELCOME!

PATIENT REGISTRATION FORM

The following confidential information is for our records only

Welcome to Dr. Heidrich's office. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Tell Us about Yourself

Dr. /Mr. / Mrs. /Miss. /Ms. (please circle) Male or Female (please circle)

(First, middle initial, last) Name_____ Date of Birth____/____/____

Home Address_____City_____State____Zip_____

Home # (_____) _____ Cell # (_____) _____

Social Security# _____-_____-_____ E-mail Address_____

Spouse/Parent/Guardian Name _____Cell/Work # (_____) _____

Employment

Full time/ Part time/ Retired/Student

Place of Employment/School _____Work# (_____) _____

Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birth date _____/_____/_____

Social Security #/or Subscriber ID # _____

Policy Owner's Employer _____

Referral: Who may we thank for referring you to our office? _____

AUTHORIZATION for TREATMENT: I request and authorize Dr. Heidrich and his staff to examine, clean and provide me with comprehensive dental treatment; including fillings, crowns, extractions, xrays, root canal therapy and nitrous oxide, if required. I further authorize the taking of dental xrays to help diagnose or treat my dental condition.

Patient (Guardian's) Signature _____