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.

PATIENT INFORMATION:

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 _____SS#_____

Spouse/Parent/Guardian Birth Date _____Hm. /Cell/Work #_____

Employment:

Full time/ Part time/ Retired

Place of Employment_____ Work#_____ Student: Yes Or No

Dental Insurance:

Insurance company _____

Insurance Co. Address: _____Insurance Co. Phone #_____

Relationship: Self Spouse Child Other

Subscriber Name _____ Subscriber DOB _____

Group # _____

Subscriber ID#_____ and/or Subscribers SS#_____

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_____