Clearwater Dental
Han and Rose

5000 West Clearwater Avenue
Kennewick, WA 99336
Phone (509) 783-5000 | Fax (509) 783-8349

Patient Name _____ Birthdate _____ Sex_____

Address _____ City _____ State _____

Zip _____SS #_____ Hm Phone # _____

Cell # _____Wk #_____ Email _____

Emergency Contact _____Phone # _____

Responsible Party *(If other than above)*

Name _____ Relationship to patient _____

Address_____ City_____ State _____Zip _____

SS # _____Hm # _____Cell # _____

Wk # _____ Birthdate _____

Primary Dental Insurance

Subscriber / Insured Name _____ Contact Phone # _____

Home Address _____ Relationship to pt _____

Birthdate _____SS # or Member ID # _____

Employer Name _____ Insurance Company _____

Claims Address _____ Group # _____ Ins Phone # _____

Secondary Dental Insurance

Subscriber/Insured Name _____ Contact Phone # _____

Home Address _____ Relationship to pt _____

Birthdate _____SS # or Member ID # _____

Employer Name _____ Insurance Company _____

Claims Address _____ Group # _____ Ins Phone # _____

Please complete this form on the backside, including your signature.

What did you like or dislike about your previous dentist?

_____

_____

_____

Please complete this registration with your signature below.

I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I am aware that all balances over 90 days will be accessed a finance charge.

In the case that I have dental insurance, I authorize and request my insurance company to pay directly to Clearwater Dental, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Therefore; I am responsible for any remaining balance.

Signature **Date**

_____ _____

(Patient or Legally Authorized Individual)

Welcome to the Clearwater Dental family. We look forward to maintaining your dental health.