ARKANSAS DENTAL HEALTH ASSOCIATES

DENTAL
REGISTRATION AND HISTORY
(PLEASE PRINT)

DANIEL J. BEAVERS, D.D.S.
105 PARK AVENUE
LINCOLN, AR 72744
(479) 824-3247

Date _____ Cell Phone _____
Home Phone _____

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
Street or PO Box	City	ST	ZIP
Sex ☐ Male ☐ Female	Age	Birthdate	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Seperated ☐ Divorced
Patient Employer	Occupation	Business Phone	
Business Street Address	City	ST	ZIP
Emergency Contact Name	Emergency Contact Phone	Whom may we thank for referring you?	

PARENT/SPOUSE INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
Street or PO Box	City	ST	ZIP
Relationship to Patient	Cell Phone or Contact Number		
Employer	Occupation	Business Phone	
Business Street Address	City	ST	ZIP

PRIMARY INSURANCE

Policy Holder Name	Relation to Patient	Birthdate	Social Security Number
Insurance Company	City	ST	ZIP
Contract #	Group#	Subscriber	
Names of other dependents covered under this plan	Is this patient covered by additional insurance? ☐ Yes ☐ No		

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions. Patient is responsible for any collection fees that may be necessary for an unpaid balance.

Responsible Party Signature	Relationship to patient	Date