



REGISTRATION

MICHAEL T. HIGGINS, D.D.S.
GENERAL DENTISTRY

PATIENT INFORMATION

first name last name nickname

gender marital status birthdate ss#

address city state zip

email

home phone work phone cell phone

whom may we thank for referring you to our office?

notify in case of emergency phone

EMPLOYMENT

patient's employer occupation

employer address

city state zip

INSURANCE

policy holder's name birthdate id#/ss#

address (if different from patients)

city state zip

policy holder's employer

insurance company group #

insurance company address phone

city state zip

AUTHORIZATION

I authorize and give consent to the performance of the dental services for myself (or my dependent). I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

patient signature date