ALLISON
& ASSOCIATES

Welcome to our practice! Please complete the following information for registration purposes.

DEMOGRAPHIC INFORMATION Name:_____
Sex: M/F DOB:_____ Preferred Name:_____Social Security#:_____ Mailing Address:_____
City:_____State:_____Zip:_____ Street Address (if different):_____
City:_____State:_____Zip:_____ Cell phone:_____Home phone:_____
Email:_____
Marital status: Married/Single/Divorced/Widower
Name of Spouse:_____
Employer:_____Occupation:_____ Work Address:_____
City:_____State:_____Zip:_____ Work phone:_____Work email:_____ Student: Yes/No School:_____

Payment Information:
Person Responsible For Payment:_____
Mailing Address:_____
City:_____State:_____Zip:_____
Dental Insurance: Yes/No
Primary Dental Insurance Company"s Name:_____
Insured's Name:_____ Insured's DOB:_____
Insured's SSN:_____Policy Number:_____
Employer Providing Insurance:_____
Secondary Dental Insurance Company"s Name:_____
Insured's Name:_____ Insured's DOB:_____
Insured's SSN:_____Policy Number:_____
Employer Providing Insurance:_____ Other Dental Insurance Information:_____
_____
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_____
_ _____

Our Financial Policy: Payment for dental treatment is due at the time of service. As a courtesy, we will file your dental insurance at the time of service and accept payment on your behalf as long as your dental insurance company allows. Payment is expected at the time of service to cover such items as deductibles, co-payments, etc. We allow 60 days for your insurance company to make payments. We make every effort to help patients with dental insurance claims. There is never a guarantee of dental insurance payment. Any balances remaining after this time are the patient's responsibility.

Signature:_____
Date:_____