PAUL A. KLOEK, DDS
W7154 Green Valley Road
Spooner, WI 54801
Phone 715-635-7888
www.greenvalleydentalcare.com

PATIENT REGISTRATION

□ **New Patient** □ **Update**

Patient Legal Full Name: ***Preferred Name***:
Date of Birth: SSN #:

□ **Male** □ **Female** Marital Status: □ Single □ Married
□ Widowed □ Divorced

Mailing Address:

Home Phone: **Cell Phone:** **Other:**

Email:

Whom May We Thank for Referring You? _____
Emergency Contact: In case of emergency, please provide information for the nearest relative or designated contact person

_____
Name Relationship Phone #

INSURANCE - Have you received, changed, or added dental insurance coverage in the past year?
YES No

Primary Dental Insurance Company:

Policy Holder/Guarantor: _____ _____ _____
Name Date of Birth Relationship to Patient (if other than patient)

Plan ID# (or policy holder SSN): _____ Insurance Through (employer): _____

Additional family member(s) under this plan: _____
Consent:

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify Green Valley Dental Care of any changes in the above information and/or my insurance/health status.
- I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.
- I authorize payment directly to **Green Valley Dental Care** of insurance benefits. I understand that my dental insurance carrier, or payer of my dental benefits, may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

Patient/Guardian Signature: _____ Date: _____