PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS IS APPOINTMENT IS FOR YOU, START HERE

LAST NAME FIRST M.I.

PREFERS TO BE CALLED BY

ADDRESS

CITY STATE ZIP

HOME PHONE FAX

BIRTHDATE AGE ☐ MALE ☐ FEMALE

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY NO.

IF THIS IS APPOINTMENT IS FOR YOUR CHILD, START HERE

LAST NAME FIRST M.I.

ADDRESS

CITY STATE ZIP

HOME PHONE CELL

FAX EMAIL

BIRTHDATE AGE ☐ MALE ☐ FEMALE

SCHOOL GRADE

SOCIAL SECURITY NO.

If your child's last name and/or address are not the same as yours, fill in the top box also

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME

RELATIONSHIP TO PATIENT SOCIAL SECURITY NO.

ADDRESS

CITY STATE ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS CITY

PHONE FAX

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER'S NAME

ADDRESS CITY

PHONE FAX

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH

RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

YOU WERE REFERRED TO US BY:

YOUR FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY

NAME

PHONE

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME

PHONE

ADDRESS

CITY STATE ZIP

PLEASE TURN OVER AND SIGN

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Witness _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____