PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date_____

Last Name_____ First_____ M.I._____ Prefers to be called by_____

Address_____ City_____ State_____ Zip_____

Home ph: _____ Cell ph:_____ Fax _____ Email_____

Birthdate_____/_____/_____ Age_____ SSN _____ Male Female Married Single Divorced Widowed

If this appointment is for your child, please continue below:

School _____ Grade _____ Parent's name if different from child_____

You were referred to us by _____

Emergency Contact _____ Relationship to patient_____

Home phone _____ Cell phone _____ Work Phone _____

Address_____ City_____ State_____ Zip_____

Closest relative not living with you _____ Relationship to patient_____ Phone_____

Address_____ City_____ State_____ Zip_____

DENTAL INSURANCE

	Primary Carrier	Secondary Carrier
Insurance Company		
Group Number		
Employer Name		
Insured's Name		
Date of birth		
Relationship to Patient		
Insured's ID number		
Insured's SSN		

ACCOUNT INFORMATION

Person Financially Responsible for Account

Name _____ SSN _____ Relationship to Patient _____

Home ph: _____ Cell ph:_____ Fax _____ Email_____

Address_____ City _____ ST _____ Zip_____

You

Name _____ Occupation _____

Employer's Name_____

Address_____ City _____ ST _____ Zip_____

Home ph: _____ Cell ph:_____ Fax _____ Email_____

Your Spouse

Name _____ Occupation _____

Employer's Name_____

Address_____ City _____ ST _____ Zip_____

Home ph: _____ Cell ph:_____ Fax _____ Email_____

CONSENT FOR TREATMENT

1. I hereby authorize the doctor or designated staff to take xrays, study models, photographs and/or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of _____'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommened 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, sedaitves and other medications 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 payment of all services rendered on my bealf 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 20% late charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____ Relationship to Patient_____

Witness _____