PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE			
LAST NAME	FIRST		MI
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL PHONE NO.	EMAIL	
BIRTHDATE	AGE	MALE / FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED
SCHOOL (IF MINIOR CHILD)	GRADE		
SOCIAL SECURITY NO.			

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME	DATE OF BIRTH		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.		
ADDRESS			
CITY	STATE	ZIP	
PHONE NO.			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS	CITY	STATE	ZIP
YOUR SPOUSE			
NAME			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS	CITY	STATE	ZIP

DENTAL INSURANCE

PRIMARY CARRIER		
INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
EMPLOYER'S NAME	INSURANCE COMPANY	GROUP NO.
INSURANCE I.D. NO.	INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER		
INSURED'S NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
EMPLOYER'S NAME	INSURANCE COMPANY	GROUP NO.
INSURANCE I.D. NO.	INSURED'S SOCIAL SECURITY NO.	

PLEASE TURN OVER AND SIGN

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?				
NAME		RELATIONSHIP		
HOW YOU WERE REFERRED TO US?				
YOUR FORMER ADDRESS				
CITY		STATE	ZIP	
PERSON TO CONTACT FOR EMERGENCY				
NAME				
PHONE NO.	ADDRESS	CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU				
PHONE NO.	ADDRESS	CITY	STATE	ZIP

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 list of any possible complications.
4. I give consent to the doctors or designated staff's use and discolsure of any oral, written or electronic health records that are individually indentifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimim 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 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 up to a 7% 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** ________________ **Witness** _______________

Parent/Responsible Party's Signature ___________________________________ **Relationship to Patient** ________________