WHOM MAY WE THANK FOR REFERRING YOU _____

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1
DATE
NAME
SPOUSE
ADDRESS
CITY STATE ZIP
HOME NO.
MOBILE NO.
WORK NO.
BIRTH DATE / AGE / MALE / FEMALE
MARRIED / SINGLE / DIVORCED / WIDOWED
SOCIAL SECURITY NO.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE
NAME
ADDRESS
CITY STATE ZIP
HOME PHONE NO.
BIRTH DATE / 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. ***

DENTAL INSURANCE 2
PRIMARY CRARIER
INSURANCE COMPANY
GROUP NO.
EMPLOYEE
DATE OF BIRTH / DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO.
EMPLOYEE SOCIAL SECURITY NO.
SECONDARY CARRIER
INSURANCE COMPANY
GROUP NO.
EMPLOYEE
DATE OF BIRTH / DATE EMPLOYED
UNION OR LOCAL NO.
EMPLOYEE NO.
EMPLOYEE SOCIAL SECURITY NO.

ACCOUNT INFORMATION 4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
NAME
RELATIONSHIP TO PATIENT
ADDRESS
CITY STATE ZIP
PHONE NO.
YOU
NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRES CITY
BUSINESS PHONE NO. EXT
YOUR SPOUSE
NAME
OCCUPATION
EMPLOYER
BUSINESS ADDRESS CITY
BUSINESS PHONE NO. EXT.

GETTING TO KNOW YOU 3
IS ANOTHER MEMBER OF YOUR FAMILY RELATIVE A PATIENT AT OUR OFFICE?
NAME: RELATIONSHIP:
IS ANOTHER MEMBER OF YOUR FAMILY RELATIVE A PATIENT AT OUR OFFICE?
YOUR FORMER ADDRESS
CITY STATE ZIP
PERSON TO CONTACT FOR EMERGENCY
PHONE NO.
ADDRESS
CITY STATE ZIP
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 any 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. Lastly, 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 a 1-1/2% late charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsibili Party_____ Relationship to Patient _____