

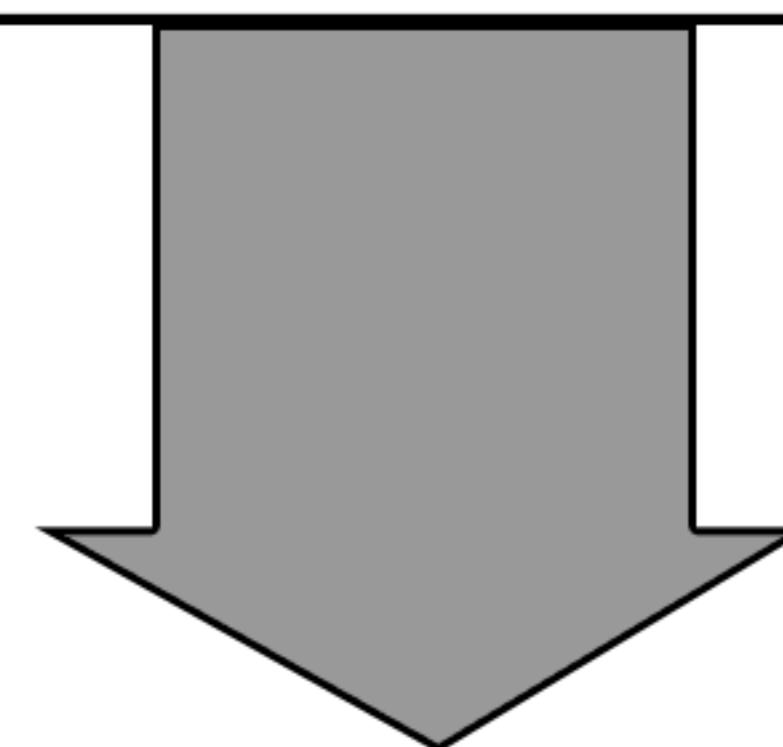
WHOM MAY WE THANK FOR REFERRING YOU

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

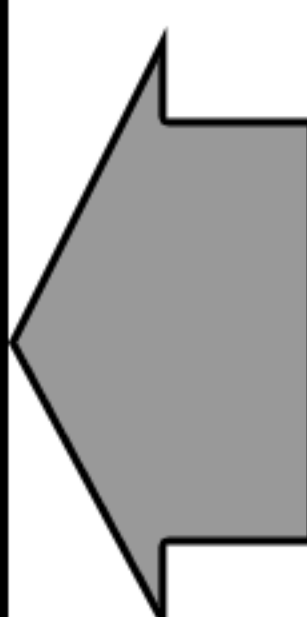


PATIENT REGISTRATION

DENTAL INSURANCE		2
PRIMARY CARRIER		
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 ADDRESS	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 Responsibility Party _____ Relationship to Patient _____