PATIENT REGISTRATION

PATIENT INFORMATION

DATE	NAME				WISHES TO BE CALLED		
SPOUSE							
ADDRESS					EMAIL		
HOME PHONE NO.			WORK			CELL	
BIRTHDATE	AGE	MALE	FEMALE	MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.							
SCHOOL				GRADE			
WHO MAY WE THANK FOR REFERRING THIS PATIENT							

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME	RELATIONSHIP TO PATIENT		
ADDRESS	CITY	STATE	ZIP
HOME #	CELL	EMAIL	

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE			
INSURANCE COMPANY	GROUP NO.	EMPLOYEE/SUBSCRIBER	
DATE OF BIRTH	DATE EMPLOYED	UNION OR LOCAL NO.	
EMPLOYEE/SUBSCRIBER I.D. NO.	EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.		

SECONDARY DENTAL INSURANCE			
INSURANCE COMPANY	GROUP NO.	EMPLOYEE/SUBSCRIBER	
DATE OF BIRTH	DATE EMPLOYED	UNION OR LOCAL NO.	
EMPLOYEE/SUBSCRIBER I.D. NO.	EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.		

ADDITIONAL INFORMATION

PERSON TO CONTACT IN AN EMERGENCY	PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?			
NAME:	RELATIONSHIP:		

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. I understand that the dental office, as a courtesy, will handle all insurance billing for the first 90 days. After such time, patient will be responsible to pay balance and to collect from insurance company. 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 _____ Initials _____

Parent or Responsible Party _____ Relationship to Patient _____