PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

If this appointment is for you, start here ->

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY	STATE		ZIP
HOME PHONE #			FAX
CELL			EMAIL
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY #			

If this appointment is for your child, start here ->

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY	STATE		ZIP
HOME PHONE #		SCHOOL	GRADE
BIRTHDATE	AGE	MALE	FEMALE
SOCIAL SECURITY #			
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, PLEASE FILL OUT THE TOP BOX ALSO			

DENTAL INSURANCE	
Primary Carrier	
Insurance Company	
Group #	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insurer's ID#	
Insurer's Social Security #	
Secondary Carrier	
Insurance Company	
Group #	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insurer's ID#	
Insurer's Social Security #	

ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	SS#
ADDRESS	
CITY	STATE/ZIP
YOU	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE #	STATE/ZIP
YOUR SPOUSE	
NAME	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE #	STATE/ZIP

 Name: ___________________________________

Getting to know you....	
Is another member of your family or relative a patient at our office?	
Name	Relationship
You were referred to us by:	
Your former address	
City	State/Zip
Person to contact for emergency	
Phone #	
Name	Address
City	State/Zip
Closest relative NOT living with you	
Phone #	
Name	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 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 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 in addition. If my account is uncollectible through normal means, a collection agency referral will be made and I will be responsible for all collection fees in addition to the outstanding balance on my account.

Patient's Signature ________________________________ Date_______________ Witness _________________

Parent/Responsible Party's Signature ______________________ Relationship to Patient ___________________