PATIENT REGISTRATION

Patient Name ____________________

Date: ____________

CONTACT INFORMATION

Address ____________________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell ____________ Work ____________ Fax ____________

Email ____________ Social Security No. ______ - ______ - ______

Birthdate ____________ Age ______ Gender: M F Marital Status: Single Married Divorced Widowed

DENTAL INSURANCE

Primary Carrier ____________ Group No. ____________

Employer Name ____________ Insured Name ____________

Date of Birth ____________ Relationship to patient ____________

Insured's I.D. No. ____________ Insured's Social Security No. ______ - ______ - ______

Secondary Carrier ____________ Group No. ____________

Employer Name ____________ Insured Name ____________

Date of Birth ____________ Relationship to patient ____________

Insured's I.D. No. ____________ Insured's Social Security No. ______ - ______ - ______

TELL US ABOUT 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 in an emergency ____________ Phone ____________

Address ____________ City ____________ State ____________ Zip ____________

Closest relative not living with you ____________ Phone ____________

Address ____________ City ____________ State ____________ Zip ____________

ACCOUNT INFORMATION

Person Financially responsible for account ____________ Relationship to patient ____________

Social Security No. ______ - ______ - ______ Phone ____________

Address ____________ City ____________ State ____________ Zip ____________

Employer Name ____________ Occupation ____________

Address ____________ Phone ____________ Fax ____________

Your Employment information

Employer Name ____________ Occupation ____________

Address ____________ Phone ____________ Fax ____________

(PLEASE TURN OVER AND SIGN)

CONSENT FOR TREATMENT

1. I hereby authorize the 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 patient ______________________________ dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary and I fully understand using anesthetic agents embodies certain risks.

3. I give consent to the doctor's, or designated staff's, use and disclosure of any oral, written, or electronic health records individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. This includes the use of my social security number. I understand only the minimum amount of information necessary to provide quality care will be used or disclosed and a notice fully outlining the protection of my personal health information is available.

4. I understand all responsibility for payment of any and all services rendered for myself or of my dependents is mine. I understand 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 a 1-1/2% late charge may be added to my account, in addition to any collection charges. If required, I also understand a check of my credit history may be made.

5. I understand it is my responsibility to inform your office of any changes to the information obtained on this form.

Patient's Signature ______________________________ Date ______________ Witness ______________

Parent/Responsible Party's Signature ______________________________

Relationship to Patient ______________________________