PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU, THEN START HERE

1

DATE	PREFERRED CONTACT NUMBER		
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
EMAIL ADDRESS			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD, THEN START HERE

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTHDATE	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.

2

DENTAL INSURANCE	
PRIMARY CARRIER	
EMPLOYER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
EMPLOYEE SOCIAL SECURITY NO.	
DATE OF BIRTH	DATE EMPLOYED
SECONDARY CARRIER	
EMPLOYER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
EMPLOYEE SOCIAL SECURITY NO.	
DATE OF BIRTH	DATE EMPLOYED

3

GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP

4

ACCOUNT INFORMATION		
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.	

CONSENT FOR TREATMENT

1) I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the 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 medications 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 am aware that a cancellation fee may apply to any appointments cancelled without a 48 hour notice.

5) 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 Responsible Party_____ Relationship to Patient_____