

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

|                         |        |          |         |          |
|-------------------------|--------|----------|---------|----------|
| DATE                    |        |          |         | <b>1</b> |
| LAST NAME               |        | FIRST    | M.I.    |          |
| PREFERS TO BE CALLED BY |        |          |         |          |
| ADDRESS                 |        |          |         |          |
| CITY                    |        | STATE    | ZIP     |          |
| PHONE                   |        |          | FAX     |          |
| CELL                    |        |          | EMAIL   |          |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |          |
| MARRIED                 | SINGLE | DIVORCED | WIDOWED |          |
| SOCIAL SECURITY NO.     |        |          |         |          |
| DATE                    |        |          |         |          |
| LAST NAME               |        | FIRST    | M.I.    |          |
| ADDRESS                 |        |          |         |          |
| CITY                    |        | STATE    | ZIP     |          |
| HOME PHONE NO.          |        |          |         |          |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |          |
| SCHOOL                  |        |          | GRADE   |          |
| SOCIAL SECURITY NO.     |        |          |         |          |

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

|                               |                         |          |
|-------------------------------|-------------------------|----------|
| DENTAL INSURANCE              |                         | <b>2</b> |
| PRIMARY CARRIER               |                         |          |
| INSURANCE COMPANY             |                         |          |
| GROUP NO.                     |                         |          |
| EMPLOYER NAME                 |                         |          |
| INSURED'S NAME                |                         |          |
| DATE OF BIRTH                 | RELATIONSHIP TO PATIENT |          |
| INSURED'S I.D. NO.            |                         |          |
| INSURED'S SOCIAL SECURITY NO. |                         |          |
| SECONDARY CARRIER             |                         |          |
| INSURANCE COMPANY             |                         |          |
| GROUP NO.                     |                         |          |
| EMPLOYER NAME                 |                         |          |
| INSURED'S NAME                |                         |          |
| DATE OF BIRTH                 | RELATIONSHIP TO PATIENT |          |
| INSURED'S I.D. NO.            |                         |          |
| INSURED'S SOCIAL SECURITY NO. |                         |          |

|   |                     |          |
|---|---------------------|----------|
| <b>ACCOUNT INFORMATION</b>                        |                     | <b>4</b> |
| <b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b> |                     |          |
| NAME  |                     |          |
| RELATIONSHIP TO PATIENT                           | SOCIAL SECURITY NO. |          |
| ADDRESS   |                     |          |
| CITY  | STATE               | ZIP      |
| PHONE NO.   |                     |          |
| <b>YOU</b>  |                     |          |
| NAME  |                     |          |
| OCCUPATION  |                     |          |
| EMPLOYER'S NAME                                   |                     |          |
| ADDRESS   | CITY                |          |
| PHONE NO.   | FAX NO.             |          |
| <b>YOUR SPOUSE</b>                                |                     |          |
| NAME  |                     |          |
| OCCUPATION  |                     |          |
| EMPLOYER'S NAME                                   |                     |          |
| ADDRESS   | CITY                |          |
| PHONE NO.   | FAX NO.             |          |

|  |               |          |
|--|---------------|----------|
| <b>GETTING TO KNOW YOU</b>   |               | <b>3</b> |
| <b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b> |               |          |
| NAME:  | RELATIONSHIP: |          |
| <b>YOU WERE REFERRED TO US BY</b>  |               |          |
| <b>YOUR FORMER ADDRESS</b>   |               |          |
| CITY   | STATE         | ZIP      |
| <b>PERSON TO CONTACT FOR EMERGENCY</b>                                       |               |          |
| PHONE NUMBER   |               |          |
| ADDRESS  |               |          |
| CITY   | STATE         | ZIP      |
| <b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>                                  |               |          |
| PHONE NUMBER   |               |          |
| 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 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. If required, I also understand a check of my credit history may be made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_