PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING INFORMATION:

IF THIS APPOINTMENT IS FOR *YOU* START HERE

DATE	EMAIL ADDRESS		
LAST NAME	FIRST	M.I.	
PREFERS TO BE CALLED BY:			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.	CELL PHONE NO.		
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR *YOUR CHILD* START HERE

DATE			
LAST NAME	FIRST	M.I.	
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.

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S SOCIAL SECURITY NO.	

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	CELL PHONE NO	

YOU

NAME		
OCCUPATION		
ADDRESS		
CITY	STATE	ZIP
WORK PHONE NO.		

YOUR SPOUSE

NAME		
OCCUPATION		
ADDRESS		
CITY	STATE	ZIP
WORK PHONE NO.		

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

PERSON TO CONTACT FOR EMERGENCY

PHONE NO.	ALTERNATE CONTACT NO.
ADDRESS	
CITY	STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

PLEASE TURN OVER AND SIGN

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 serviced rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If this account is assigned to a collection agency, an **additional fee of 40% of the amount owed will be added**.

Patient's Signature_____Date_____Witness_____

Parent/Responsible Party's Signature _____ Relationship to Patient _____