PATIENT REGISTRATION. PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION.

IF THIS APPT IS FOR YOU START HERE

DATE			1
LAST NAME	FIRST	M.I	
PREFERS TO BE CALLED			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE N°.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY N°.			

IF THIS APPT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST	M.I	
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE N°.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY N°.			

If your child's last name and/or address are not the same as yours, fill in the top box also

DENTAL INSURANCE	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP N°	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. N°.	
INSURED'S SOCIAL SECURITY N°	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP N°	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. N°.	
INSURED'S SOCIAL SECURITY N°	

GETTING TO KNOW YOU	3
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 NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

ACCOUNT INFORMATION	4
PERSON FINANCIALLY RESPONSABLE FOR ACCOUNT	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY N°.
ADDRESS	
CITY	STATE ZIP
PHONE NUMBER	
YOUR	
NAME	
OCCUPATION	
EMPLOYERS'S NAME	
ADDRESS	CITY
PHONE NUMBER	FAX N°.
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYERS'S NAME	
ADDRESS	CITY
PHONE NUMBER	FAX N°.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and 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 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. 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_____