

REGISTRATION

Date _____

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____
Soc. Sec. # _____ PREFERRED NAME _____
Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME Last _____ First _____ Middle _____ MARITAL STATUS _____
MAILING ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____
OTHER Family Members in this practice _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____
E-MAIL ADDRESS _____
SOCIAL SECURITY # _____ BIRTHDATE _____ RELATION TO PATIENT _____
EMPLOYER _____ OCCUPATION _____

EMERGENCY INFORMATION

NAME Last _____ First _____ RELATION TO PATIENT _____
HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

INSURED'S NAME Last _____ First _____
INSURANCE COMPANY _____ PHONE _____
INSURANCE COMPANY ADDRESS Street _____ City _____ State _____ Zip _____
INSURED'S EMPLOYER _____
INSURED'S SOCIAL SECURITY #/ Subscriber ID # _____ Birthdate _____ Group # _____

If you have double dental insurance coverage, complete this for the second coverage

INSURED'S NAME Last _____ First _____
INSURANCE COMPANY _____ PHONE _____
INSURANCE COMPANY ADDRESS Street _____ City _____ State _____ Zip _____
INSURED'S EMPLOYER _____
INSURED'S SOCIAL SECURITY # _____ Birthdate _____ Group # _____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I authorize release of any information concerning my (or my child's) healthcare, advice and treatment to another dentist. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date _____