PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTAL INFORMATION_____

DATE:_____

NAME:_____SPOUSE:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE:_____CELL PHONE :_____

EMAIL ADDRESS:_____CONFIRM APPTS AT EMAIL :Y____N_____

BIRTH DATE:_____AGE:_____MALE:_____FEMALE_____

SOCIAL SECURITY NUMBER: _____DRIVER'S LICENSE #_____

MARRIED: _____SINGLE:_____DIVORCED:_____

PATIENT IS CHILD: _____

ADDRESS: (IF DIFFERENT FROM ABOVE)_____

BIRTHDATE:_____ AGE:_____MALE:_____FEMALE:_____

SCHOOL:_____GRADE:_____

DENTAL INSURANCE NAME:_____POLICYHOLDER: _____

EMPLOYER_:_____ GROUP NUMBER:_____

MEMBER ID#:_____BIRTHDATE OF EMPLOYEE:_____

SECONDARY INSURANCE: _____ POLICYHOLDER___ _____

EMPLOYER:GROUP NUMBER:_____ MEMBER ID#:_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:_____

OCCUPATION:_____EMPLOYER:_____

SPOUSE:_____EMPLOYER:_____

YOU WERE REFERRED TO OUR OFFICE BY:_____

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT HERE?_____

EMERGENCY PERSON:_____EMERGENCY NUMBER:_____

CONSENT: The undersigned, hereby authorizes 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 in connection with (name of Patient _____ _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge(18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.

Patient:_____Date:_____

Witness_____Parent of Responsible Party_____Relationship to Patient_____