PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name Last_____**First**_____**MI**_____ **Sex M F Birthdate**_____

Home Address_____**City**_____**State**_____**Zip**_____

Name I prefer to be called_____**Home Phone**_____**Cell Phone**_____**Text? Y/N**

EMAIL_____**Social Security#**_____

Spouse/Partner's Name_____**If patient is a Minor, Parent/Guardian**_____

How did you hear about our office?_____

PERSON RESPONSIBLE FOR BILL

Name Last_____**First**_____**MI**_____

Home Address_____**City**_____**State**_____**Zip**_____

Home Phone_____ **Work Phone**_____**OK Call? Y/N**

Social Security # _____ **Birthdate** _____ **Relationship to Patient**_____

Employer_____**Occupation**_____

Primary Dental Insurance

Name_____
Last **First** **MI**

Insurance Co_____

Employer_____

Group #_____**Ins. Phone #**_____

Local #_____**Relationship to Patient**_____

Secondary Dental Insurance

Name_____
Last **First** **MI**

Insurance Co._____

Employer_____

Group #_____**Ins. Phone #**_____

Local #_____**Relationship to Patient**_____

Emergency Information

Whom should we contact in case of an emergency?

Name_____

Phone_____

Relationship_____

Closest Relative Not Living With You

Name_____

Address_____

City_____**State**_____**Zip**_____

Phone #_____

CONSENT

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the 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 understand that my dental insurance is a contract between the insurance carrier, and me 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 authorize the release of any information including diagnosis and the records of any treatments or examinations rendered, to my insurance company(s). 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.

PATIENT Signature (Parent or Guardian of Child)_____**Date**_____