

Registration

First Name: _____ Last Name: _____ (Mr., Mrs., Ms., Miss, Dr.)

What do you preferred to be called? (Nickname) _____

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Work/Alt Phone: _____

Email address: _____

Marital Status: M / S / D Male ___ Female ___ Social Security _____ Birthdate: _____

If you are a full time student, please list school name and address: _____

How did you hear about our office? _____

Insurance Information

Employer or Company Name: _____

Employee Name: _____ Employee Social Security or ID# _____

Insurance Company Name: _____ Phone # _____

Policy Name: _____ Group # _____

Secondary Insurance Information

Employer or Company Name: _____

Employee Name: _____ Employee Social Security or ID# _____

Insurance Company Name: _____ Phone # _____

Policy Name: _____ Group # _____

Who should we contact in case of emergency: _____

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 the 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 dental 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 understand that insurance is submitted as a courtesy and that all 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 other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2 late charge (18% APR) may be added to my account, in addition to collection charges. If required, I also understand a check of my credit history may be obtained.
5. 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.

Patient Signature _____ Date _____

Parent/Responsible Party’s signature _____ Relationship to Patient: _____