PATIENT REGISTRATION Date________________

Patient_____________________________ _____________________________ ________
Last Name First Name Initial
Preferred Nick Name _____________________ Patient SS#___________________________
Address ____
E-Mail Address ___________________________ Mobil phone #________________________
Home phone#______________________ Work phone#______________ Sex: M F
Date of Birth:______________________ Marital Status : Married Single
Emergency Contact Name___________________________ Phone #____________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
Name_______________________________ _____________________________ _________
Last Name First Name Initial
Employer______________________________ Occupation_____________________________
Business Address____
Spouse's Name__________________________ Employed by_____________________________
Business phone#________________________

DENTAL INSURANCE INFORMATION
Employee Name__________________________ Employed by_____________________________
Insurance Company_________________________________ Group #______________________
Employee SS#/ ID#__________________________________ Employee Birth date___________
Patient Relationship to Employee: Self Spouse Son Daughter Other
If Full Time Student: School__________________________ City___________________________

SECONDARY COVERAGE
Employee Name _________________________ Employed by ____________________________
Insurance Company ________________________________ Group #______________________
Employee SS#/ ID#__________________________________ Employee Birth date____________
Patient Relationship to Employee: Self Spouse Son Daughter Other
If Full Time Student: School__________________________ City___________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand my signature will be used as a "signature on file" for insurance processing.

SIGNATURE____ DATE_______________________
Patient or Parent/Guardian, if Minor
FOR NEW PATIENTS ONLY
Are other members of your immediate or extended family patients at our office? Yes No
Name(s) ____
Whom may we thank for referring you? ____
Closest Relative not living with you ________________________________ Phone #__________
Address ____

CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of ____ dental needs.

(Name of Patient)

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and doctor to employ such assistance as required to provide such recommended treatment.

3. I consent to use of appropriate medication and therapy as deemed necessary by doctor after consultation with me. I fully understand that using anesthetic agents embodies a certain risk.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents, whether or not the services are covered by insurance. I understand that payment is due at the time of service unless other arrangements have been made prior to time of service.

5. In the event that my account is referred out for collection, I agree to pay any and all fees and court costs incurred in the collection of my delinquent account balance in addition to the amount owed by me.

SIGNATURE OF PATIENT____ DATE__________________

FOR MINOR CHILD
SIGNATURE OF PARENT/RESPONSIBLE PARTY____

DATE______________________

Relationship to patient ____