

PATIENT REGISTRATION

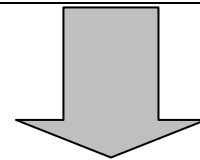
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



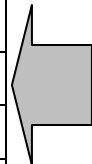
DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL			EMAIL	
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL			GRADE	
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION	
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT	
4	
NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY	STATE ZIP
PHONE NO.	
YOU	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.
YOUR SPOUSE	
NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.



GETTING TO KNOW YOU	
3	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
YOU WERE REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE ZIP
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deem appropriate by doctor to make a thorough diagnosis of (name of 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 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 give consent to the doctor's 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.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 – ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____