PATIENT REGISTRATION

Please complete the following confidential information. To better serve you we require each area to be filled completely, if something does not apply write N/A

A. DATE_____ FOR OFFICE ONLY_____/___/___

PATIENT LAST NAME_____FIRST_____M.I._____

PREFERS TO BE CALLED_____BIRTH DATE_____AGE_____

SOCIAL SECURITY #_____SEX_____ MARITAL STATUS_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME TELEPHONE_____CELL _____ WORK _____

DAYTIME #_____EMAIL ADDRESS_____

EMPLOYER NAME/ADDRESS_____

REFERRED BY_____ MAY WE THANK THEM BY LETTER_____

PREFERRED PHARMACY_____ PHONE #_____

(If Applicable) NAME OF SCHOOL_____YEAR_____

(If Applicable)SPOUSE'S/ PARTNER'S NAME_____SPOUSE/ PARTNER'S WORK #_____

B. (If you have brought your Dental Card with you, you can omit section B!)

PRIMARY DENTAL INSURANCE

INSURED'S NAME_____DOB_____RELATIONSHIP TO INSURED_____

SSN_____GROUP#_____ EMPLOYER NAME_____

INSURED'S ID#_____INSURANCE COMPANY_____

SECONDARY DENTAL INSURANCE

INSURED'S NAME_____DOB_____ RELATIONSHIP TO INSURED_____

SSN_____GROUP#_____ EMPLOYER NAME_____

INSURED'S ID#_____INSURANCE COMPANY_____

C. (If Patient is responsible for account, write patient by NAME and the rest of section C can be omitted).

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME_____RELATIONSHIP TO PATIENT_____SSN_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____

D.

EMERGENCY CONTACT

NAME_____PHONE #_____

ADDRESS_____CITY_____STATE_____ZIP_____

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME_____PHONE#_____

ADDRESS_____ CITY_____STATE_____ZIP_____

/ / /	/ / /	/ / /

FOR OFFICE USE ONLY _____/___/___/ _____/____/____/ _____/____/____/

DISCLAIMER:

Parents are *required* to remain in this dental office during their child's dental visits. This affords parents the opportunity to ask questions and our staff the opportunity to explain and discuss our findings. Also, circumstances may arise that require a change in dental treatment, resulting in fee differences. If parental consent cannot be obtained, we reserve the right to continue with treatment deemed necessary or to discontinue treatment and reschedule the appointment. In certain instances, written permission from the custodial parent will be sufficient to allow another party to bring this child to a scheduled dental appointment.

1. I agree to be present at _____ dental appointments.
   (Child's name)

_____/_____
Signature of parent/custodial parent Date

Consent for Treatment

1. I hereby authorize doctor or designated staff to perform a thorough examination, take x-rays, study models, photographs, and other diagnostic aids deemed 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 medications 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 agree to be responsible for payment of all services rendered on my behalf or my dependent's, and it is understood that the dentist will not bill a third party for payment on my or my child's behalf. I understand that payment is due at the time service is rendered unless written arrangements have been made with this office prior to treatment. In the event that payments are not received by agreed upon dates, I understand that a late charge may apply and will be added to my account. If required, I also understand that a check of my credit history may be made.

Patient's Signature _____Date _____ Witness_____

Parent/Responsible Party's Signature _____Relationship to patient _____

Submit