Today's Date:_____

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

Your Information

First Name | Last | M.I. | Prefers to be called

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Birth date | Age | Gender | Marital Status

Social Security Number | Employer's Name | Occupation

If Dental Insurance is your policy and through the above employer, please complete the following.

Insurance Company | Insurance Phone Number | Policy Number | Group Number

Please list the names of all persons covered under this policy

Your Spouse's Information

First Name | Last | M.I. | Prefers to be called

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Birth date | Age | Gender | Marital Status

Social Security Number | Employer's Name | Occupation

If Dental Insurance is your spouse's policy and through the above employer, please complete the following.

Insurance Company | Insurance Phone Number | Policy Number | Group Number

Please list the names of all persons covered under this policy

Account Information

Person Financially Responsible for Account | Relationship to you | Responsible Party's Social Security Number

If Responsible Party's address is different or not listed above, please complete the following.

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Getting to Know You

Is another member of your family or a relative a patient at our office? Name | Relationship

You were referred to us by | Your former address

Emergency Contact

Name | Phone | Address | City | State | Zip

Closest Relative Not Living With You

Name | Phone | Address | City | State | Zip

Please Turn Over and Complete Reverse Side

Signature

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 _____'s dental needs.
(Name of Patient)
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 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_____

Parent/Responsible Party's Signature_____Date_____

Relationship to Patient_____