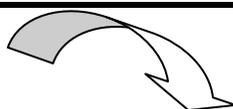


PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

Children's Information	First Name	Last	M.I.	Prefers to be called	Date of Birth	Gender	
						M F	
	First Name	Last	M.I.	Prefers to be called	Date of Birth	Gender	
						M F	
	First Name	Last	M.I.	Prefers to be called	Date of Birth	Gender	
					M F		
Father'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 child(ren)'s mother's policy and through the above employer, please complete the following.						
	Insurance Company	Insurance Phone Number	Policy Number	Group Number			
Mother'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 child(ren)'s mother's policy and through the above employer, please complete the following.						
	Insurance Company	Insurance Phone Number	Policy Number	Group Number			
Account Information	***Please inform the Front Desk Staff if children are covered under any insurance policy other than those listed above***						
	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



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.

Signature

Parent/Responsible Party's Signature _____ Date _____

Relationship to Patient _____