ROBERT W. HAAG, DDS

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGIESTRATION

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
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

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.

Parent/Responsible Party's Signature_____Date_____

Relationship to Patient_____