PATIENT REGISTRATION

Patient's name: ______________________ Birthdate: ____________ Single ☐

Widowed ☐

Name of Spouse: ______________________ Birthdate: ____________ Married ☐

Divorced ☐

If a child, parent's name: ______________________ Separated ☐

Street Address: ______________________ Phone: ____________

City: ______________________ State: ________ Zip: ____________

Email: ______________________

Patient employed by: ______________________ Phone: ____________

Business Address: ______________________

Present position: ______________________ How long held: ____________

Purpose of this appointment: ______________________

In case of emergency, who should be notified? ______________________ Phone: ____________

Person responsible for this account: ______________________

Social Security Number: ______________________

Drivers License Number: ______________________ State: ____________

Spouse's Social Security Number: ______________________

Spouse's Drivers License Number: ______________________

How will you be paying for your visits? Cash ________ Check ________ Visa/MC ________ Amex ________

If using charge card, Name: ______________________ Card No.: ____________ Exp. Date: ____________

If you have insurance, name of insured: ______________________

Name of Insurance Company: ______________________ Policy No.: ____________

If spouse has insurance, name of insured: ______________________

Name of insurance company: ______________________

Whom may we thank for referring you? ______________________

General Consent:

The undersigned hereby authorizes the doctor to use X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs.

I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with.

(Name of Patient/Guardian) ______________________

Patients failing to keep scheduled appointments without 24 hours notice may be charged for an office visit.

I understand that using anesthetic agents &/or nitrous oxide embodies a certain risk. Furthermore, I understand that all responsibility for payment for dental service provided in this office for myself or my dependents is mine, due & payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account. I agree to pay any attorney and collection fees if this account is turned over for collection.

I understand that even though the doctor will file my insurance for me as a courtesy, I am responsible for the total amount due.

All diagnostic aids & documentation are the property of the practice. Records may not be taken by the patient. All records are confidential & will not be released without written permission of the patient, parent, or legal guardian.

X ______________________ ______________________

Patient/Parent/Legal Guardian (Date) Doctor (Date)