

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				<b>1</b>
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
MAILING ADDRESS IF DIFFERENT				
HOME PHONE NO.		CELL NO.		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.		DRIVER'S LICENSE NO.		
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		CELL NO.		
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				



DENTAL INSURANCE		<b>2</b>
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE	
EMPLOYER		
EMPLOYEE SS # or ID #		
EMAIL ADDRESS		

<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	

<b>GETTING TO KNOW YOU</b>		<b>3</b>
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**You may Refuse to sign This Acknowledgement**

**I have received a copy of this office's Notice of Privacy Practices**

\_\_\_\_\_  
**Please print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**TO OUR DENTAL INSURANCE PATIENTS**

We accept assignment of insurance benefits as a courtesy and service to our patients. We will help you receive the full benefits of your insurance coverage, but we can make no guarantee of any estimated coverage. Because the insurance policy is an arrangement between you and your insurance company, we need to emphasize that all patients are financially responsible for the entire account.

Patient \_\_\_\_\_

**CONSENT**

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any 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 consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
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 1-1/2% finance charge (18% APR) may be added to my account. If financial arrangements become necessary, a copy of credit report will be required.
5. I have read the office guidelines regarding payments, insurance, and appointments.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_