PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START

DATE			1
NAME			
SPOUSE			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATW	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
NAME			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'D LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2

PRIMARY CARRER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE OF EMPLOYEDE
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, ____ have reviewed and/or Received a copy of this office's

Notice of Privacy Practices.

_____________________________________ _____________________________________ _______________

Please Print Name Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of you Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

____

____

____

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 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). Lastly, 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.

5). Any and all collection agency fees will be the patient's responsibility.

Patient ____Date _________________ Witness ________________

Parent or Responsible Party ______________________________________Relationship to Patient _________________