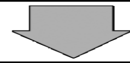
PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

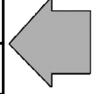
DATE			1
LAST NAME		FIRST	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		WORK NO.	
CELLPHONE NO.		E-MAIL	
BIRTHDATE	AGE	MALE ☐	FEMALE ☐
MARRIED ☐	SINGLE ☐	DIVORCED ☐	WIDOWED ☐
SOCIAL SECURITY NO.			

DATE			
LAST NAME	FIRST	M.I.	
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		WORK NO.	
BIRTHDATE	AGE	MALE ☐	FEMALE ☐
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	2
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D.NO.	
INSURED'S SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D.NO.	
INSURED'S SOCIAL SECURITY NO.	



GETTING TO KNOW YOU		3
PERSON TO CONTACT FOR EMERGENCY - RELATIONSHIP		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU - RELATIONSHIP		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

PHARMACY NAME
PHARMACY PHONE
PATIENT INFORMATION UPDATE ADDRESS
PATIENT INFORMATION UPDATE PHONE
DATE

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 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. 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 services unless other arrangements have been made. 1.1/2% late charge (18%APR) may be added to my account.

CONSENT FOR TREATMENT

Patient________________________________Date_________Witness__________________

Parent or Responsible Party_____________________Relationship to Patient______________