PATIENT REGISTRATION

FOR ADULTS			
Date			
Last Name	First Name	M.I.	
Prefers to by called by			
Address			
City	State	Zip	
Home Phone No.	Cell No.		
Social Security No.	Email		
Birthday	Age	Male	Female
Married	Single	Divorced	Widowed

FOR CHILDREN			
Date			
Last Name	First Name	M.I.	
Address			
City	State	Zip	
Home Phone no.	Social Security No.		
Birthday	Age	Male	Female
School			Grade

DENTAL INSURANCE		
PRIMARY CARRIER		
Insurance Company		
Group No.	Insured's ID No.	Insured's Social Security No.
Employer Name	Insured's Name	
Date of Birth	Relationship to patient	
SECONDARY CARRIER		
Insurance Company		
Group No.	Insured's ID No.	Insured's Social Security No.
Employer Name	Insured's Name	
Date of Birth	Relationship to patient	

GETTING TO KNOW		
Is another member of your family or relative a patient at our office? Name:		
Relationship		
YOU WERE REFERRED TO US BY		
Name		
PERSON TO CONTACT FOR EMERGENCY		
Name		
Cell No.	Home Phone No.	
Address		
City	State	Zip

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
Relationship to patient	Social Security No.	
Address		
City	State	Zip
Phone No.		
YOU		
Name	Phone No.	
Occupation		
Employer's Name		
Address	City	
YOUR SPOUSE		
Name	Phone No.	
Occupation		
Employer's Name		
Address	City	

CONSENT FOR TREATMENT

1. I hearby 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 (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.

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3. I agree to the use of anesthetics 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 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient’s examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney’s fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

Patient's Signature	Date	Witness
Parent/Responsible Party's Signature		Relationship to Patient