WELCOME TO OUR PRACTICE

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE AND LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.

PATIENT REGISTRATION

Today's date: _____
Who may we thank for referring you to our office? _____
Patient's Name:
Last_____ First_____ Middle Initial_____
Street_____ Apt. # ____ City _____State _____Zip_____
Home Phone_____Work_____Cell_____
Social Security # _____ Drivers License #_____ Sex: M F
Birthday _____ Age_____ E-mail_____
Employer_____Occupation_____# of yrs employed_____

RESPONSIBLE PARTY

(If different)

Name Last_____First_____Middle Initial_____
Street_____ Apt. #_____City_____ State _____Zip_____
Home Phone_____Work_____Cell_____
Social Security#_____ Drivers License#_____ Sex: M F
Birthday_____ Employer _____E-Mail_____

EMERGENCY INFORMATION

(Not living with you)

Name_____Relationship_____Address_____
City_____State____Zip_____HmPhone_____Work_____Cell_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Identification #_____
Insurance Company_____ Address_____
City _____State _____Zip _____Insurance Company's phone #_____
Insured's Social Security #_____Insured's Birthday_____
Insured's Employer_____ Group number_____

Consent

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit, reports may be obtained.

PATIENT SIGNATURE (Parent of Child)_____Date:_____