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____________________________

Number of years employed______

PREFERRED PHARMACY ____

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_______

Home Phone______________________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:__________________________