

Registration Form

Today's Date _____ Male _____ Female _____ Marital Status _____
Name _____ Date of Birth _____
Address _____ Apt. No. _____
City _____ State _____ Zip Code _____
Home Phone No. _____ Work Phone No. _____
Cell Phone/Pager _____ E-Mail Address _____
(If you want to be contacted this way)
Social Security No. _____ Driver's License No. _____
Person to contact in case of emergency _____

Patients
Information

Name _____ Relationship to Patient _____
Address _____ City, State, Zip Code _____
(If different from above)
Home Phone No. _____ Work Phone No. _____
Social Security No. _____ Driver's License No. _____

Responsible
Party

Employee Name _____ Employer Name _____
Insurance Co. _____ Group Number _____
Employee Date of Birth _____ Employee Social Security No. _____

Insurance
Information

Who may we thank for referring you to our office:

Referred
By:

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. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, 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.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) and any expenses such as attorney fees if engaged for the purpose of collections may be added to my account.

Patient or Responsible Party _____ Date _____