Registration Form

Patients Information

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_____

Responsible Party

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. _____

Insurance Information

Employee Name _____ Employer Name _____

Insurance Co. _____ Group Number _____

Employee Date of Birth _____ Employee Social Security No. _____

Referred By:

Who may we thank for referring you to our office:

_____

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 _____