

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

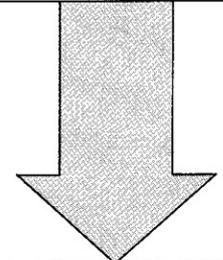


|                         |        |          |         |          |
|-------------------------|--------|----------|---------|----------|
| DATE                    |        |          |         | <b>1</b> |
| LAST NAME               |        | FIRST    | M.I.    |          |
| PREFERS TO BE CALLED BY |        |          |         |          |
| ADDRESS                 |        |          |         |          |
| CITY                    |        | STATE    | ZIP     |          |
| PHONE                   |        | FAX      |         |          |
| CELL                    |        | EMAIL    |         |          |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |          |
| MARRIED                 | SINGLE | DIVORCED | WIDOWED |          |
| SOCIAL SECURITY NO.     |        |          |         |          |
| DATE                    |        |          |         |          |
| LAST NAME               |        | FIRST    | M.I.    |          |
| ADDRESS                 |        |          |         |          |
| CITY                    |        | STATE    | ZIP     |          |
| HOME PHONE NO.          |        |          |         |          |
| BIRTHDATE               | AGE    | MALE     | FEMALE  |          |
| SCHOOL                  |        | GRADE    |         |          |
| SOCIAL SECURITY NO.     |        |          |         |          |



IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

|                               |                         |          |
|-------------------------------|-------------------------|----------|
| DENTAL INSURANCE              |                         | <b>2</b> |
| PRIMARY CARRIER               |                         |          |
| INSURANCE COMPANY             |                         |          |
| GROUP NO.                     |                         |          |
| EMPLOYER NAME                 |                         |          |
| INSURED'S NAME                |                         |          |
| DATE OF BIRTH                 | RELATIONSHIP TO PATIENT |          |
| INSURED'S I.D. NO.            |                         |          |
| INSURED'S SOCIAL SECURITY NO. |                         |          |
| SECONDARY CARRIER             |                         |          |
| INSURANCE COMPANY             |                         |          |
| GROUP NO.                     |                         |          |
| EMPLOYER NAME                 |                         |          |
| INSURED'S NAME                |                         |          |
| DATE OF BIRTH                 | RELATIONSHIP TO PATIENT |          |
| INSURED'S I.D. NO.            |                         |          |
| INSURED'S SOCIAL SECURITY NO. |                         |          |



|  |                     |          |
|--|---------------------|----------|
| ACCOUNT INFORMATION                        |                     | <b>4</b> |
| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT |                     |          |
| NAME                                       |                     |          |
| RELATIONSHIP TO PATIENT                    | SOCIAL SECURITY NO. |          |
| ADDRESS                                    |                     |          |
| CITY                                       | STATE               | ZIP      |
| PHONE NO.                                  |                     |          |
| YOU  |                     |          |
| NAME                                       |                     |          |
| OCCUPATION                                 |                     |          |
| EMPLOYER'S NAME                            |                     |          |
| ADDRESS                                    | CITY                |          |
| PHONE NO.                                  | FAX NO.             |          |
| YOUR SPOUSE                                |                     |          |
| NAME                                       |                     |          |
| OCCUPATION                                 |                     |          |
| EMPLOYER'S NAME                            |                     |          |
| ADDRESS                                    | CITY                |          |
| PHONE NO.                                  | FAX NO.             |          |



|   |               |          |
|---|---------------|----------|
| GETTING TO KNOW YOU   |               | <b>3</b> |
| IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? |               |          |
| NAME:   | RELATIONSHIP: |          |
| YOU WERE REFERRED TO US BY  |               |          |
| YOUR FORMER ADDRESS   |               |          |
| CITY  | STATE         | ZIP      |
| PERSON TO CONTACT FOR EMERGENCY                                       |               |          |
| PHONE NUMBER  |               |          |
| ADDRESS   |               |          |
| CITY  | STATE         | ZIP      |
| CLOSEST RELATIVE NOT LIVING WITH YOU                                  |               |          |
| PHONE NUMBER  |               |          |
| ADDRESS   |               |          |
| CITY  | STATE         | ZIP      |

## CONSENT FOR TREATMENT

1. I hereby 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.
3. I agree to the use of anesthetics, 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.
4. 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.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_