

PATIENT REGISTRATION

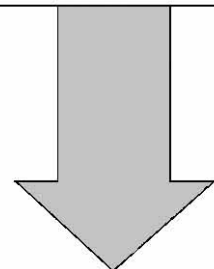
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



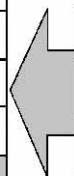
DATE				1			
LAST NAME		FIRST		M.I.			
PREFERS TO BE CALLED BY							
ADDRESS							
CITY		STATE		ZIP			
HOME PHONE NO.				FAX			
CELL				EMAIL			
BIRTHDATE		AGE		MALE		FEMALE	
MARRIED		SINGLE		DIVORCED		WIDOWED	
SOCIAL SECURITY NO.							
DATE							
LAST NAME		FIRST		M.I.			
ADDRESS							
CITY		STATE		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		2	
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		4	
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		3	
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 give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. 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 _____