

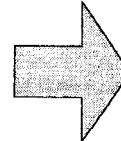
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

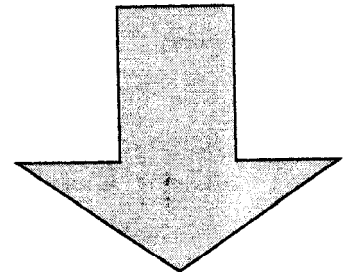
IF THIS
APPOINTMENT
IS FOR YOU
START HERE

IF THIS
APPOINTMENT IS
FOR YOUR CHILD
START HERE

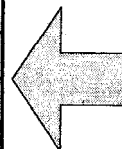
DATE				1
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE		CELL PHONE		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.		E-MAIL		
DATE				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE		CELL PHONE		
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL			GRADE	
SOCIAL SECURITY NO.		E-MAIL		
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.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION or LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH	DATE EMPLOYED	
UNION or LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE	EXT.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS	CITY	
BUSINESS PHONE NO.	EXT.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME	RELATIONSHIP	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP

CONSENT

1. 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 _____'s dental needs.
(name of patient)
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, 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 date, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____