PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:_____ First Name: _____MI:_____

Nickname/Preferred Name: _____ Male:_____ Female: _____

Married _____ Single _____ Child _____ Other _____ Birthdate:____/ ____ / ____

If married, name of spouse: _____

SS#_____ Driver's License#_____

Address: _____City: _____State:_____Zip: _____

E-mail Address (for Internet communications)_____

Home Phone#:_____ Work Phone#: _____Ext: _____

Fax#: _____ Pager#: _____ Cell#: _____

Occupation: _____ Employer: _____

Who may we thank for referring you to our office:_____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Relationship to Patient: _____

Last Name:_____ First Name: _____MI:_____

Nickname/Preferred Name: _____Male: _____ Female: _____

Married _____ Single _____ Child _____ Other _____ Birthdate:____/ ____ / ____

SS#_____ Driver's License#_____

Address: _____City: _____State:_____Zip: _____

E-mail Address (for Internet communications)_____

Home Phone#:_____ Work Phone#: _____Ext: _____

Fax#: _____ Pager#: _____ Cell#: _____

Occupation: _____ Employer: _____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

Insured's Name_____

Insured's Address _____

_____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insured's Employer_____

Insured's Soc. Sec #:_____Group #_____

IF YOU HAVE DOUBLE DENTAL INSURANCE COVERAGE, COMPLETE THIS FOR THE SECOND COVERAGE.

Insured's Name_____

Insured's Address _____

_____

Insurance Co. _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Insured's Employer_____

Insured's Soc. Sec #:_____Group #_____

I authorize this office to provide any insurance company, health care service plan, self insurers, or their representatives, any and all information and records about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claims for benefits. **Initials** _____

If we take photos of your smile, after your review and concurrence, may we make them available to others to promote our cosmetic procedures... - in our office? ❑ Yes ❑ No - on our web site? ❑ Yes ❑ No -in our outside advertising? ❑ Yes ❑ No

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred, I further understand that a late charge will be added to any overdue balance, I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____Date _____ DENTIST Signature_____