Family & Cosmetic Dentistry of Fairfield
Mariana Conant, DDS, LLC

Registration Form

Patient Information

Legal Name: _____ Preferred Name: _____ Birth Date: _____

Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Phone No.:_____ Work Phone No.:_____

Cell Phone No.: _____ May we send you text message reminders? ☐Yes ☐No

Email Address: _____ May we contact you by email? ☐Yes ☐No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed Sex: ☐F ☐M

Social Security No.:_____ Driver's License No.: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____Relationship to you: _____ Phone No.: _____

Whom may we thank for referring you to our office? Internet/newspaper/other (please specify): _____ _____

Responsible Party Information

Legal Name: _____Relationship to patient: _____

Address: _____City, State, Zip: _____

Home Phone No.: _____ __Work Phone No.: _____ Cell Phone No.:_____

Social Security No.:_____ Driver's License No.: _____

Primary Insurance Information		*Secondary Insurance Information*	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Subscriber Birth Date		Subscriber Birth Date	
Relationship	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone #		Employer Phone #	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	

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 agreements 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. Any and all information provided above can be used for collection purposes.

Patient or Responsible Party Signature: _____Date: _____