DRS. PERRY & TYLER, FAMILY & COSMETIC DENTISTRY — PATIENT REGISTRATION

190 San Marin Drive, Suite A, Novato, CA 94945

Date__________

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME ______________________ SPOUSE ______________________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

HOME PHONE ______________ WORK PHONE ______________ CELL PHONE ______________

E-MAIL ADDRESS ______________________________

BIRTHDATE ______________ AGE ______ MALE O FEMALE O

MARRIED O SINGLE O DIVORCED O WIDOWED O CHILD O

SOCIAL SECURITY NUMBER ______________________

(IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING)

PARENT/GUARDIAN'S NAME ______________________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

DENTAL INSURANCE

PRIMARY INSURANCE COMPANY ______________________ GROUP # ______

EMPLOYEE NAME ______________ DATE OF BIRTH ______________ DATE EMPLOYED ______

UNION OR LOCAL NUMBER ______________ EMPLOYEE SOCIAL SECURITY # ______________

SECONDARY INSURANCE COMPANY (IF APPLICABLE) ______________________ GROUP # ______

EMPLOYEE NAME ______________ DATE OF BIRTH ______________ DATE EMPLOYED ______

UNION OR LOCAL NUMBER ______________ EMPLOYEE SOCIAL SECURITY # ______________

ACCOUNT INFORMATION (PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT)

NAME ______________________ RELATIONSHIP TO PATIENT ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______ PHONE # ______

OCCUPATION ______________ EMPLOYER ______________

BUSINESS ADDRESS ______________ CITY ______________ STATE ______ ZIP ______ PHONE # ______

SPOUSE'S NAME ______________________

OCCUPATION ______________ EMPLOYER ______________

BUSINESS ADDRESS ______________ CITY ______________ STATE ______ ZIP ______ PHONE # ______

PATIENT INFORMATION

REFERRED TO US BY ______________ EMERGENCY CONTACT PERSON ______________ PHONE # ______

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

CLOSEST RELATIVE NOT LIVING WITH YOU ______________________ PHONE # ______

ADDRESS ______________ CITY ______________ STATE ______ ZIP ______

CONSENT FOR TREATMENT

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 patients 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 local anesthetics, sedatives, and other medication as necessary. I fully understand that using local anesthetics embodies certain risks. I understand that I can ask for a complete recital of any possible complications
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand 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 a 1-1/2 late charge (18% APR) may be added to my account

PARENT OR RESPONSIBLE PARTY ______________________ DATE ______

(SIGNATURE)