John F. Robison DMD, MAGD

Patient Registration

Patient's Name ____
Last First Middle Preferred Name

Address____
Street City State Zip

Home #_____________ Cell #_____________ Work #_____________ Email ________________________

S.S. # _________________________________ Date of Birth ________/__________/__________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Whom may we thank for referring you? ____

Dental Insurance Information

*Please do not repeat information unless it is different from above

Insured's Name ____
Last First Middle

Address____
Street City State Zip

Insured's S.S. # _________________________ Date of Birth _______/________/_________

Primary Carrier	Secondary Carrier
Dental Insurance Company ______________________	Dental Insurance Company ______________________
Phone Number ________________________________	Phone Number ________________________________
Address ____________________________________ Street	Address ____________________________________ Street
____ City State Zip	____ City State Zip
Group # ____________________________________	Group # ____________________________________
ID # _______________________________________	ID # _______________________________________
Employer Name _______________________________	Employer Name _______________________________

In case of an emergency, who should be notified?

Name ____________________________________

Home #________________ Cell #________________ Work #________________

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.

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Patient's Signature Date

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Parent/Responsible Party's Signature Relationship to Patient