NEW PATIENT REGISTRATION

Today's Date_____/_____/_____

Patient name_____ NICKNAME: _____

SS#_____-_____-_____ Birthdate _____/_____/_____ Age _____

If Minor: Mom:_____ Phone #_____

Dad: :_____ Phone #_____

Address _____ City_____State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell (_____) _____-_____ TEXT YES NO

EMAIL:_____

Occupation _____ Employer_____

Circle One: Single Married Separated Divorced Widowed Student at _____

Physician's Name_____ Dentist's Name_____

Whom May We Thank For This Referral_____

Emergency Contact:_____ Relationship to Patient_____

Home/Work Phone(_____) _____-_____ Mobile Phone(_____) _____-_____

Party Responsible for Payment of Account_____

DENTAL INSURANCE

Name of Insured_____ __ Employer_____

Name of Dental Insurance Company_____ Phone(_____) _____-_____

Address of Dental Insurance Company_____

Policy or Group #_____ SS# _____ Birthdate_____/_____/_____

RELEASE

I authorize Dr. Boltchi to perform diagnostic procedures and treatment as may be necessary for proper care. I authorize release of any information concerning my (or my child's) health/dental care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and the payment of insurance benefits directly to the doctor, otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Boltchi or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Patient Signature_____ DATE _____/_____/_____
(Parent or Guardian)