PATIENT REGISTRATION Date :_____

Name : _____
Last Name First Name M.I

Email address : _____

Nickname : _____ Date of Birth : _____ Age _____

Address : _____
Number and street

_____
City State Zipcode

Home Phone Number : _____ Work Phone Number : _____

Cell Phone Number : _____ Social Security Number : _____

Emergency Contact : _____
Name and Relationship Phone

Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐

General Dentist : _____ Who referred you to this office? _____

DENTAL Primary Insurance Information
Primary Carrier

Insurance Company : _____ Group Number : _____

I.D Number : _____ Employer Name : _____

Is the insurance under your name? Yes ☐ No ☐ (then please fill out additional information below)

Name of Insured : _____ Is insured a patient? Yes ☐ No ☐

Insured's Birth Date : _____Insured's social security Number : _____

DENTAL - Secondary Carrier (if applicable)
Insurance Company : _____ Group Number : _____

I.D Number : _____ Employer Name : _____

Is the insurance under your name? Yes ☐ No ☐ (then please fill out additional information below)

Name of Insured : _____ Is insured a patient? Yes ☐ No ☐

Insured's Birth Date : _____Insured's social security Number : _____

PLEASE TURN OVER AND READ AND SIGN

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 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 ½ % late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____ Date _____

Parent / Responsible Party's Signature：_____ Relationship to Patient_____