


PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date _____
 If you are the patient . . .


Name		Spouse	
Address			
City		State	Zip
Home Phone #		Work #	
Cell / Mobile #		Back-up #	
SS#		Driver's license #	
Birth date	Age		
		Male	Female
Married	Single	Divorced	Widowed

REIMBURSEMENT PLAN	
Insurance Company	
Group No.	
Employee	
Date Employed	
Union or Local No.	
Employee No.	
Employee SS#	



GETTING TO KNOW YOU	
Name you preferred to be called by	
Is another member of your family or relative a patient at our office?	
Name	Relationship
Whom may we thank for referring you?	
Your E-mail Address	
How often do you check your E-mail?	
Where do you work?	
Your Occupation	
Emergency Contact	Relationship
Phone #	
Address	
City	State Zip
Who do we contact if we absolutely must get hold of you	
Name	Phone #
Address	
City	State Zip



ACCOUNT INFORMATION	
Person Financially Responsible for Account	
Name	
Relationship to Patient	
Home Address	
City	State Zip
Home Phone #	Cell #
SS #	Driver's License #
Occupation	
Employer	
Business Address	
Business Phone #	Ext.

Please turn over, read and sign



Consent For Treatment

1. I hereby authorize doctor or designated staff to take radiographs, 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 my 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.

Patient's Signature _____ date _____ witness _____

Parent / Responsible Party's Signature _____ Relationship to Patient _____