PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ SSN#: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Occupation: _____ Sex: ❑ Male ❑ Female Status: ❑ Single ❑ Married ❑ Minor ❑ Other

Referred By: _____

Person to Contact In An Emergency: _____ Phone: _____

PREFERRED COMMUNICATION METHOD

Select all that apply:

❑ Email ❑ Text Message (standard rates may apply) ❑ Phone Call (Check one) ○Mobile ○Home ○Work

Do we have permission to contact you and leave messages on your preferred communication method(s)? ❑ YES ❑ NO

PRIMARY INSURANCE

Person Responsible for Account: _____ Relation to Patient: _____

SSN# _____ Driver's License: _____ Birth Date: _____

Work Phone: _____ Mobile Phone: _____ Email Address: _____

Insurance Carrier: _____ Group#: _____ Union Local#: _____

Employer: _____

Employer Address: _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ❑ Yes ❑ No

Name of Insured: _____ Relation to Patient: _____

SSN# _____ Birth Date: _____

Work Phone: _____ Mobile Phone: _____ Email Address: _____

Insurance Carrier: _____ Group#: _____ Union Local#: _____

Employer: _____

Employer Address: _____

AUTHORIZATION FOR INSURANCE AND CONSENT FOR TREATMENT

I authorize my insurance company to pay to the doctor all insurance benefits otherwise payable to me for services rendered and authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible of all charges whether or not paid by insurance.

I hereby authorize doctor/staff to take X-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (or my child's) dental needs. 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. 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.

X _____ _____

Patient Signature Or Legal Guardian / Representative Signature Date