## PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

## **PATIENT REGISTRATION**

	DATE 1					]	DENTAL INSURANCE 2			
	LAST NAME FIRST M.I				M.I.	PRIMARY CARRIER				
	PREFERS TO BE CALLED BY						INSURANCE COMPANY			
IF THIS	ADDRESS						GROUP NO.			
APPOINTMENT IS FOR YOU	CITY STATE				ZIP		EMPLOYER NAME			
START HERE	HOME PHONE NO. FAX						INSURED'S NAME			
	CELL		EMAIL		DATE OF BIRTH		RELATIONSHIP TO PATIENT			
V	BIRTHDATE	AGE	MALE	F	EMALE		INSURED'S I.D. NO.			
	MARRIED	SINGLE	DIVORCED	V	VIDOWED		INSURED'S SOCIAL	SECURITY NO.		
	SOCIAL SECURITY NO.						SECONDARY CARRIER			
	DATE						INSURANCE COMPANY			
	LAST NAME FIRST				M.1.		GROUP NO.			
IF THIS	ADDRESS						EMPLOYER NAME			
APPOINTMENT IS FOR YOUR CHILD	CITY STATE				ZIP		INSURED'S NAME			
START HERE	HOME PHONE NO.						DATE OF BIRTH	RELATIONSHIP TO PATIENT		
	BIRTHDATE	IRTHDATE AGE MALE			FEMALE		INSURED'S I.D. NO.			
V	SCHOOL				GRADE		INSURED'S SOCIAL S	SECURITY NO.		
SOCIAL SECURITY NO.  IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAM										
					AS YOURS, FILL IN THE TOP BOX ALSO					
ACCOUNT INFORMATION 4										
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT										
NAME										
RELATIONSHIP TO	PATIENT S	OCIAL SECURITY NO	Э.			OFT	TINO TO IQUOUN			
ADDRESS					IS ANOTHER MEM		TING TO KNOW Y	<u> </u>		
CITY STATE ZIP					IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?  NAME: RELATIONSHIP:  YOU WERE REFERRED TO US BY					
PHONE NO.										
YOU					YOUR FORMER A					
NAME						DDKESS				
OCCUPATION					CITY STATE ZIP					
EMPLOYER'S NAME				1	PERSON TO CONTACT FOR EMERGENCY					
ADDRESS	CITY				PHONE NUMBER					
PHONE NO.	FAX NO.			/_	ADDRESS					
YOUR SPOUSE	YOUR SPOUSE				CITY		STATE	ZIP		
NAME					CLOSEST RELATIVE NOT LIVING WITH YOU					
OCCUPATION					PHONE NUMBER					
EMPLOYER'S NAME										
ADDRESS CITY					ADDRESS					
PHONE NO. FAX NO.					CITY		STATE	ZIP		

## 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) <a href="mailto:sstart contents">'s dental needs.</a>
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.	Lagree 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.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_