PATIENT REGISTRATION

Patient Name_____ Phone Number_____ Cell Phone/Pager_____

Address_____ City_____ State_____ Zip_____

Email address_____

Occupation_____ Employer_____

Business Address_____ Business Phone Number_____ Ext._____

Social Security Number_____ Date of Birth_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (Skip if same as above)

Name_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Occupation_____ Employer_____

Business Address_____ Business Phone Number_____ Ext._____

Social Security Number_____ Relationship to Patient_____

YOUR SPOUSE

Name_____ Business Phone Number_____

Occupation_____ Employer_____ Social Security Number_____

Business Address_____ City_____ State_____ Zip_____

DENTAL INSURANCE

Primary Carrier

Employee_____ Employer_____

Insurance Company_____ Group Number_____

Social Security Number_____ Date of Birth_____

Secondary Carrier

Employee_____ Employer_____

Insurance Company_____ Group Number_____

Social Security Number_____ Date of Birth_____

GETTING TO KNOW YOU

Whom may we thank for referring you to our office? _____

Is another member of your family or relative a patient at our office?

Name_____ Relationship_____

Person to contact for emergency

Name_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Closest relative not living with you

Name_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY: This is to certify that I, Undersigned: (1) Consent to the performing of the Dental Procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated: (2) Consent to releasing information to my insurance company: (3) Agree to pay the fees associated with the dental procedures, including the award of reasonable costs and attorney's fees, at trial and on appeal, as determined by the court for the legal efforts necessary to obtain the fees.

Signature of Patient (or guardian if minor)_____ Date_____