# PATIENT REGISTRATION

Patient Information

Last Name_____ First Name_____ Middle I.____ Preferred Name_____
Address_____ City,State,Zip_____
Home Ph._____ Work Ph._____ext._____ Cell Ph._____
Email_____
Age _____ Gender _____ Marital Status_____ Spouse's Name _____
Date of Birth_____ Social Security Number _____
Occupation_____ Employer_____
Person to Contact in Emergency_____ Phone_____
Names of Other Family Members that are Patients in our Office _____
Who Referred You?/How did You Learn about our Office? _____

Responsible Party (if someone other than the patient)

Last Name_____ First Name_____ Middle I.____ Relation to Patient_____
Address_____ City,State,Zip_____
Home Ph._____ Work Ph._____ext._____ Cell Ph._____
Email_____
Date of Birth_____ Social Security Number _____
Occupation_____ Employer_____

Primary Insurance Information

Insurance Company_____
Group Number_____ ID Number_____
Employer Name_____
Name of Insured_____
Date of Birth_____
Social Security Number_____
Relation to Patient_____

Secondary Insurance Information

Insurance Company_____
Group Number_____ ID Number_____
Employer Name_____
Name of Insured_____
Date of Birth_____
Social Security Number_____
Relation to Patient_____

Consent for Treatment

I hereby authorize the doctor or designated staff to take x-rays,study models, photos, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of:

(patient name)_____.

Upon such diagnosis, I authorize the 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 dental anesthetics, sedatives, and other medication as necessary. I fully understand that using these drugs embodies certain risks (adverse reaction, nerve or muscular damage, bleeding, infection, etc.). I understand that the results/outcome of dental treatment is influenced by factors outside of the doctor's control and that more extensive treatment could ultimately be required. I give consent to the doctor or designated staff to use and disclose 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 a notice fully outlining the protection of my personal health information is available.

Patient Signature_____ Date_____

Parent/Responsible Party's Signature_____ Relation to Patient_____