

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

## PATIENT REGISTRATION

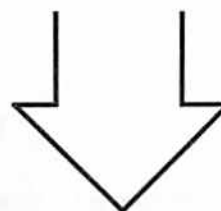
IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				<b>1</b>
NAME				
SPOUSE				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		<b>CELL PHONE</b>		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
<del>EMAIL ADDRESS</del>				
NAME				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				
<small>IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO</small>				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

<b>DENTAL INSURANCE</b>		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYEE		
DATE OF BIRTH		
UNION OR LOCAL NO.		
EMPLOYEE NO.		
EMPLOYEE SOCIAL SECURITY NO.		

<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY		STATE ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		CITY
BUSINESS PHONE NO.		EXT.
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER		
BUSINESS ADDRESS		
BUSINESS PHONE NO.		



<b>GETTING TO KNOW YOU</b>		<b>3</b>
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
<b>REFERRED TO US BY</b>		
<b>YOUR FORMER ADDRESS</b>		
CITY		STATE CITY ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY		STATE CITY ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY		STATE CITY ZIP

Please turn over and sign

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## CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any 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 by 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. Lastly, 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.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Patient or Responsible Party \_\_\_\_\_ Relationship to Patient \_\_\_\_\_