PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

	DATE					1		
						DENTAL INSURANCE 2		
1	LAST NAME FIRST				M.I.		PRIMARY CARRIER	
	PREFERS TO BE CALLED BY						INSURANCE COMPA	NY
IFTHIS	ADDRESS						GROUP NO.	
APPOINTMENT IS FOR YOU	CITY STATE				E ZIP		EMPLOYER NAME	
START HERE							INSURED'S NAME	
	CELL		EMAIL			DATE OF BIRTH	RELATIONSHIP TO PATIENT	
/	BIRTHDATE	AGE	MALE	FE	EMALE	1	INSURED'S I.D. NO.	
	MARRIED	SINGLE	DIVORCED	W	IDOWED	1	INSURED'S SOCIAL S	SECURITY NO.
SOCIAL SECURITY NO.						>	SECON	DARY CARRIER
1	DATE						INSURANCE COMPA	NY
	LAST NAME	AST NAME FIRST			M.I.		GROUP NO.	
IFTHIS	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	AGE	MALE	F	EMALE		INSURED'S I.D. NO.	
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SOCIAL SECURITY NO.								
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CONSENT FOR TREATMENT

1.	I hereby authorize do	octor or design	ated staff to	take x-rays, st	rudy models, p	hotographs,
	and other diagnostic	aids deemed	appropriate I	by doctor to r	make a thorou	gh diagnosis
	of (name of patient)			A Part of Land	's dental n	eeds.

- 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. 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	