PATIENT REGISTRATION

Thank you for choosing our office.
In order to properly serve you we will need the following information.
All information is strictly confidential.

PATIENT INFORMATION

Date | Patient - Last Name | First Name | Initial | Preferred Name

Address | City | State | Zip

Sex | Age | Birthdate | Single | Married | Widowed | Separated | Divorced

☐ M ☐ F ☐ ☐ ☐ ☐ ☐ ☐

Employed By | Occupation

Social Security Number | Home Phone | Bus. Phone

EMERGENCY CONTACT INFORMATION

Spouse Name | Spouse's Social Security Number

Spouse Employed By | Occupation

Business Address | Business Phone

Relative NOT Living With You | Phone

Home Address | City | State | Zip

Employed By | Phone

Business Address | City | State | Zip

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name and Relationship | Birthdate

Address | City | State | Zip

Phone | Bus. Phone | Social Security Number

( ) ( )

DENTAL INSURANCE INFORMATION 1ST COVERAGE

EMPLOYEE NAME | BIRTHDATE

EMPLOYER | SOCIAL SECURITY NUMBER

INSURANCE COMPANY | POLICY NO. | GROUP NO.

ADDRESS | CITY | STATE | ZIP

UNION LOCAL OR GROUP

DENTAL INSURANCE INFORMATION 2ND COVERAGE

EMPLOYEE NAME | BIRTHDATE

EMPLOYER | SOCIAL SECURITY NUMBER

INSURANCE COMPANY | POLICY NO. | GROUP NO.

ADDRESS | CITY | STATE | ZIP

UNION LOCAL OR GROUP

REFERRAL INFORMATION

Whom may we thank for referring you?

Street Address | City | State | Zip

Please Turn Over And Sign

CONSENT

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 consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
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% finance charge (18% APR) may be added to my account. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.

Patient _____ Date _____ Witness _____

Parent or Responsible Party_____ Relationship to Patient _____

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize the health care provider to submit claims for payment for services to the health care service plans or insurance companies named, on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

_____	_____	_____
(NAME OF PATIENT)	*(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)*	*Date*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the physician, dentist or other health care provider to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, and association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall remain effective for up to five years from this Date.

I know that I have the right to receive a copy of this authorization if requested.

_____	_____	_____
(NAME OF PATIENT)	*(SIGNATURE OF PATIENT, PARENT OR GUARDIAN)*	*Date*