PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

	DATE						DENTA	LINSURANCE 2		
٨	LAST NAME FIRST				M.I.		PRIMARY CARRIER			
	PREFERS TO BE CALLED BY						INSURANCE COMPANY			
IF THIS APPOINTMENT IS FOR YOU	ADDRESS						GROUP NO.			
	CITY STATE			ZIP		EMPLOYER NAME				
START HERE	HOME PHONE NO.		FAX	FAX			INSURED'S NAME			
	CELL		EMAIL				DATE OF BIRTH	RELATIONSHIP TO PATIENT		
	BIRTHDATE	AGE	MALE	FE	MALE		INSURED'S I.D. NO.			
	MARRIED	SINGLE	DIVORCED	WI	DOWED	11/	INSURED'S SOCIAL SECURITY NO.			
	SOCIAL SECURITY NO.						SECONDARY CARRIER			
N	DATE						INSURANCE COMPANY			
	LAST 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.			
/	SCHOOL			G	BRADE		INSURED'S SOCIAL	SECURITY NO.		
	SOCIAL SECURITY NO.									
	IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAM			AS YOU	DURS, FILL IN THE TOP BOX ALSO					
	ACCOUNT IN	IFORMATION	4							
PERSON FINA	NCIALLY RES	SPONSIBLE FO	R ACCOUNT							
NAME										
RELATIONSHIP TO	PATIENT	SOCIAL SECURIT	Y NO.			GE	TTING TO KNOW	YOU 3		
ADDRESS					IS ANOTHER M		OUR FAMILY OR RELA			
CITY	CITY STATE ZIP					AT OUR OFFICE? NAME: RELATIONSHIP:				
PHONE NO.					YOU WERE REI	FERRED TO U				
YOU	7				YOUR FORMER	ADDRESS				
NAME					CITY		STATE	ZIP		
OCCUPATION				1	PERSON TO CO	NITACT EOD				
EMPLOYER'S NAM	ME						EWENGENCY			
ADDRESS		CITY	<u> </u>		PHONE NUMBE	:R				
PHONE NO.		FAX NO.			ADDRESS					
YOUR SPOUS	E			V	CITY		STATE	ZIP		
NAME					CLOSEST RELATIVE NOT LIVING WITH YOU					
OCCUPATION					PHONE NUMBE	R				
EMPLOYER'S NAM	VIE	OLT.			ADDRESS					
ADDRESS		CITY			CITY		STATE	ZIP		
PHONE NO.		FAX NO.			3111		SIAIL	211		

CONSENT FOR TREATMENT

1.	I hereby authorize doctor or designated staff to take x-rays, study models, phand other diagnostic aids deemed appropriate by doctor to make a thorougo of (name of patient)	ıh diagnosis						
2.	 Upon such diagnosis, I authorize doctor to perform all recommended mutually agreed upon by me and to employ such assistance as required proper care. 							
3.	 I agree to the use of anesthetics, sedatives and other medication as neces understand that using anesthetic agents embodies certain risks. I unders can ask for a complete recital of any possible complications. 							
4.	4. I give consent to the doctor's or designated staff's use and disclosure of any written or electronic health records that are individually identifiable as mine purpose of carrying out my treatment, payment and health care operations understand that only the minimum amount of information necessary to provide will be used or disclosed and that a notice fully outlining the protection personal health information is available.	for the i. I ide quality						
5.	5. I agree to be responsible for payment of all services rendered on my be dependents. I understand that payment is due at the time of service arrangements have been made. In the event payments are not received upon dates, I understand that a 1-1/2% late charge (18% APR) may be added account. If required, I also understand a check of my credit history may	I understand that payment is due at the time of service unless other s have been made. In the event payments are not received by agreed understand that a 1-1/2% late charge (18% APR) may be added to my						
	_							
Patient's Signatu	ture Date Witness	***************************************						

Parent/Responsible Party's Signature _____

_____ Relationship to Patient _____