Registration Form

Patient's Information

Today's Date _____ Male _____ Female _____ Marital Status _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone No. _____ Work Phone No. _____

Cell Phone No. _____ Email Address _____

Social Security No. _____

Emergency Contact _____ Phone No. _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____ City, State, Zip Code _____

Home Phone No. _____ Work Phone No. _____

Cell Phone No. _____ Social Security No. _____

Insurance Information

Employee Name _____ Employer Name _____

Insurance Co. _____ Group No. _____

Employee Date of Birth _____ Social Security Number _____

Insurance Information

Employee Name _____ Employer Name _____

Insurance Co. _____ Group No. _____

Employee Date of Birth _____ Social Security Number _____

Referred By:

Who may we thank for referring you to our office:

_____

How would you prefer to be notified of your appointments ?

Home #_____ Cell # _____ Work # _____ Email (W) _____ (H)_____

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. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, 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.

Patient or Responsible Party _____ Date _____

Relationship to Patient _____