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 ______________________________