

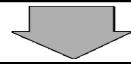
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		WORK NO.		
CELLPHONE NO.		E-MAIL		
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		WORK NO.		
BIRTHDATE	AGE	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	
SOCIAL SECURITY NO.				
IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO				



DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D.NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D.NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



GETTING TO KNOW YOU			3
PERSON TO CONTACT FOR EMERGENCY - RELATIONSHIP			
PHONE NUMBER			
ADDRESS			
CITY	STATE	ZIP	
CLOSEST RELATIVE NOT LIVING WITH YOU - RELATIONSHIP			
PHONE NUMBER			
ADDRESS			
CITY	STATE	ZIP	

PHARMACY NAME
PHARMACY PHONE
PATIENT INFORMATION UPDATE ADDRESS
PATIENT INFORMATION UPDATE PHONE
DATE

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 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. 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 services unless other arrangements have been made. 1.1/2% late charge (18%APR) may be added to my account.

CONSENT FOR TREATMENT

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____