Patient Registration

Date____________

Last Name ______________________ First Name______________________ Preferred name______________________

Address __________________________________City ______________________State ________ Zip __________

Home phone __________________ Fax ______________ Cell _______________ e-mail _________________________

Birth date ________________ Married ___ Single ___ Divorced ___ Widowed ___

Employer's name ____ How long? ________________

Address _____________________________________ Phone no. ________________Occupation ________________

Name of Spouse (or parent if a minor): Name ____

Employer Name and address____Work# _____________

Person Financially Responsible for account

Name ____ Relationship to Patient ___________________________

Address _______________________________ City ___________State _______ Zip _______ Phone no.__________

Primary Insurance Carrier information

Insurance company _________________________ Group No. _________Employer Name _____________________

Subscriber Name ____ Social Security No. _________________________

Subscriber Date of Birth _______________________

Secondary Insurance Carrier information

Insurance company _________________________ Group No. _________Employer Name _____________________

Subscriber Name ____ Social Security No. _________________________

Subscriber Date of Birth _______________________

Who can we thank for referring you to our Practice? ____

Consent for treatment

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor 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.

2. 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.

3. 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% late charge (18% APR) may be added to my account.

4. I understand that notice for a change in my appointment must be given at least one weekday (Mon.-Fri.) in advance to a staff member or doctor to avoid a charge to my account.

Patient signature

__________________________________Date_________________Witness________________________

Parent/Responsible Party's signature ________________________________Relationship_________________________