PATIENT REGISTRATION
(Please print)

Name _____
(Last, First, Middle) Nickname

Address _____

City _____ State _____ Zip _____

Phone _____ / _____ / _____ Soc. Sec. # _____
Home Office Cell

Date of Birth _____ Present Age _____ ○ Male ○ Female

○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Minor

Occupation _____ Employer _____ Since _____

Employer's Address _____
Street City

Spouse _____ Soc. Sec. # _____ Date of Birth _____

Occupation _____ Employer _____ Since _____

Employer's Address _____

E-mail address _____

Person Responsible For Account (If different from above)

Name _____ Relationship _____
Address _____ Soc. Sec. # _____
Occupation _____ Employer _____ Since _____

Insurance Group #

Primary _____
_____

Secondary _____
_____

In Case of Emergency Contact

Name of nearest relative _____ Relationship _____
Address _____ Phone _____
_____

Who Referred You To Our Office

Name _____ Relationship _____
Address _____

Authorization, Terms & Conditions

I grant authority to the Dentist to perform procedures and treatment, including administration of medicine, local and general anesthetics, and extractions along with other surgical and dental procedures that may be necessary. I have received (or have been offered) a copy of this office's Notice of Privacy Practices and "The Dental Materials Fact Sheet". By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment, and health care operation purposes.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If your insurance carrier does not remit payment within 60 days, the balance will be due and payable by you. Please have your completed insurance claim form with you at the first visit.

AUTHORIZED SIGNATURE _____ Date _____
Witness Initials _____