

# Registration Form

Today's Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Cell Phone/Pager \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
(If you want to be contacted this way)

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Patients  
Information

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_  
(If different from above)

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Responsible  
Party

Employee Name \_\_\_\_\_ Employer Name \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group Number \_\_\_\_\_

Employee Date of Birth \_\_\_\_\_ Employee Social Security No. \_\_\_\_\_

Insurance  
Information

Who may we thank for referring you to our office:  
\_\_\_\_\_

Referred  
By:

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.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) and any expenses such as attorney fees if engaged for the purpose of collections may be added to my account.

Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_