REGISTRATION FORM

TODAY'S DATE ____________

PATIENT INFORMATION:

Full Name: ____ Nickname:_____________________ Sex:____________

Address:____ Apt #:_________ City:____________________

State:__________ Zip Code:_____________ Home Phone #:____________________ Cell Phone #:_________________

Work Phone #:_____________________ Email Address:____

Social Security #:________________________________ Driver's License #:_____________________________________

Date of Birth:_________________________ Referred By:_____________________________________

Emergency Contact Name:_________________________ Relationship:_____________ Cell Phone #:________________

INSURANCE INFORMATION:

Employee Name:_________________________ Date of Birth:________________ Social Security #:________________

Employer Name:________________________________ Group#:___________________ ID #:______________________

Insurance Company:_____________________________ Phone #:_____________________ Payor ID#:_______________

RESPONSIBLE PARTY:

Name:___________________________________ Relationship:_____________________ Date of Birth:______________

Address:____ City, State, Zip:_____________________________________

Home Phone #:____________________________ Cell Phone #:________________________

Social Security #:________________________________ Driver's License #:_____________________________________

I hereby authorize doctor or designated staff to take xrays, 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. 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/Responsible Party _______________________________________ Date _________________________