PATIENT INFORMATION:

NAME:_____ HOME PHONE:_____

EMAIL:_____ CELL PHONE: _____

ADDRESS: _____ CITY:_____ STATE: ZIP:_____

SEX	M	F	DATE OF BIRTH	MON	DAY	YR	AGE	MARITAL STATUS	S	M	W	D	WEIGHT:	HEIGHT:

SOCIAL SECURITY #_____

EMPLOYER'S NAME:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS_____ BUS. PHONE:_____

DENTAL INSURANCE:

INSURED PARTY:_____ SOCIAL SECURITY #_____

CARRIER:_____ POLICY:_____

SEND CLAIMS TO:_____

OTHER:

PREVIOUS DENTIST'S NAME & ADDRESS:_____

_____

PHYSICIAN'S NAME & ADDRESS:_____

IN CASE OF EMERGENCY, NOTIFY: _____ PHONE:_____

RELATIONSHIP TO PATIENT:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

FINANCIAL POLICY:

EMERGENCY CARE - All emergency care patients are expected to pay for their treatment at the end of that visit.

DENTAL INSURANCE - If you have dental insurance please ask our receptionist for information concerning our policy.

NO DENTAL INSURANCE - Payment is due at the time of service. We accept cash, checks, Visa and Mastercard.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 11/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

REGISTRATION FORM