## **PATIENT REGISTRATION**

IF THIS **APPOINTMENT** IS FOR YOU

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:



**START HERE** 

IF THIS APPOINTMENT

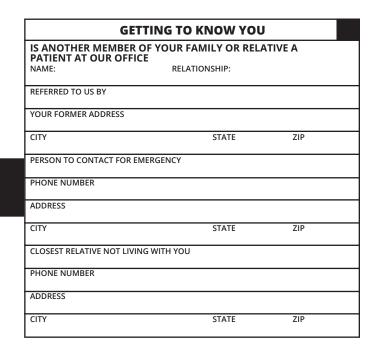
IS FOR YOUR CHILD.

**START HERE** 

DATE NAME SPOUSE ADDRESS CITY STATE ZIP HOME PHONE NO. BIRTHDATE AGE MALE FEMALE MARRIED SINGLE DIVORCED WIDOWED SOCIAL SECURITY NO. DATE NAME ADDRESS CITY STATE ZIP HOME PHONE NO. BIRTHDATE AGE MALE FEMALE SCHOOL GRADE SOCIAL SECURITY NO. IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE				
PRIMARY CARRIER				
INSURANCE COMPANY				
GROUP NO.				
EMPLOYEE				
DATE OF BIRTH DATE EMPLOYED				
UNION OR LOCAL NO.				
EMPLOYEE NO.				
EMPLOYEE SOCIAL SECURITY NO				
SECONDARY CARRIER				
INSURANCE COMPANY				
GROUP NO.				
EMPLOYEE				
DATE OF BIRTH DATE EMPLOYED				
UNION OR LOCAL NO.				
EMPLOYEE NO.				
EMPLOYEE SOCIAL SECURITY NO.				
	PRIMARY CARRIER  INSURANCE COMPANY  GROUP NO.  EMPLOYEE  DATE OF BIRTH DATE EMPLOYED  UNION OR LOCAL NO.  EMPLOYEE SOCIAL SECURITY NO  SECONDARY CARRIER  INSURANCE COMPANY  GROUP NO.  EMPLOYEE  DATE OF BIRTH DATE EMPLOYED  UNION OR LOCAL NO.  EMPLOYEE  DATE OF BIRTH DATE EMPLOYED  UNION OR LOCAL NO.  EMPLOYEE NO.			

## **ACCOUNT INFORMATION** PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT RELATIONSHIP TO PATIENT ADDRESS CITY STATE ZIP PHONE NUMBER YOU NAME OCCUPATION EMPLOYER **BUSINESS ADDRESS** CITY BUSINESS PHONE NUMBER EXT. **YOUR SPOUSE** NAME OCCUPATION EMPLOYER BUSINESS ADDRESS CITY **BUSINESS PHONE NUMBER** EXT.



## **CONSENT FOR TREATMENT**

1.	I hereby authorize doctor of designated staf any other diagnostic aids deemed appropria (name of patient)	ate by doctor	to make a thorough diagnosis of		
2.	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.				
3.	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.				
4.	Lastly, I agree to be responsible for payment for 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.				
Pat	atient	_ Date	Witness		
Parent or Responsible Party			_ Relationship to Patient		