PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE.

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE.

1

DATE

NAME

SPOUSE

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

CELL PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

DATE

NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

CELL PHONE NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

EMPLOYER

EMPLOYER PHONE NO.

EMPLOYEE SOCIAL SECURITY NO. or ID NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

EMPLOYER

EMPLOYER PHONE NO.

EMPLOYEE SOCIAL SECURITY NO. or ID NO.

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

Please turn over and sign

PRIDE SYSTEMS

CONSENT

1. 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.

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 consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of 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. A $25 fee may be assessed for each missed appointment.

Patient_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____