NEW PATIENT REGISTRATION

PATIENT INFORMATION

Date _____

Name_____ Date of Birth_____ Age_____ Sex M or F

Current Address_____ City_____ State_____ Zip_____

Permanent Address _____ City_____ State_____ Zip_____

Home Phone_____ Employer_____ Work Phone_____

E-mail_____ Mobile Phone_____ Pager_____

SS#_____ Driver's License #_____ Marital Status_____

Spouse's Name_____ Employer _____

Person to contact for emergency_____ Phone_____

Whom may we thank for referring you to our office?_____

PARTY RESPONSIBLE FOR ACCOUNT

Name_____ Date of Birth_____ Age_____ Sex M or F

Address_____City_____ State_____ Zip_____

Home Phone_____ SS#_____ Driver's License #_____

Employer_____ Work Phone_____

INSURANCE INFORMATION

_____ _____

Insured person's full name — Date of Birth

_____ _____ _____

Relationship to patient — Social Security Number — Work Phone

_____ _____ _____

Insurance Company — Group Name — Group Number

_____ _____

Employer's Name — Full address of employer

PAYMENT OPTIONS

___1. Cash and personal checks.

___2. MasterCard, Visa, American Express, and Discover.

___3. If you have dental insurance, we accept assignment of your insurance payment as a service to you. This means that **you** are responsible for your deductible and your portion the insurance does not cover **at the time of service. Remember, you are responsible for the account if the insurance company does not honor their commitment to you and us.**

CONSENT AGREEMENT

I hereby authorize the doctor and staff to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the above patient. I also understand that previous to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or her staff. I agree to pay for all services provided by this office.

_____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE