PATIENT REGISTRATION FORM

Patient Name_________________________________ Date of Birth_______________ Today's Date____________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient Address____

City____State_________Zip_________

SS#____________________________________ Driver's License #___________________________________

Person Responsible for this Account______________________________Relationship______________________

Address__________________________________City__________________State_________Zip__________

Employer______________________________________Occupation____________________________________

Employer's Address__________________________City__________________State_________Zip__________

Who may we thank for referring you to our practice? ____

CONTACT INFORMATION/APPOINTMENTS

When you make an appointment, it is your responsibility to be here. If you request, we will confirm your appointments by the method indicated below. If your preference or the numbers change, please inform us. If you are unable to make your appointment, kindly notify us at least 48 hours in advance. When our time is repeatedly wasted and other patients must wait because of you, we will charge a fee. ____________Initial

Please indicate how you can be reliably contacted.

#1) Phone # ____________________________ ☐ Home ☐ Work ☐ Cell

#2) Phone #____________________________ ☐ Home ☐ Work ☐ Cell

#3) Email_________________________________

DENTAL INSURANCE INFORMATION

Primary	Secondary
Insured's Name ________________________	Insured's Name ________________________
Insurance Co.__________________________	Insurance Co. __________________________
Insured's Employer _____________________	Insured's Employer _____________________
Insured's Soc. Sec. # ___________________	Insured's Soc. Sec. # ___________________
Date of Birth ______________Group # ________	Date of Birth ______________Group # ________

PAYMENT REPSONSIBILITY

Although we make every effort to work with you in obtaining your insurance benefits, our services are rendered with the understanding that the patient is ultimately responsible for all fees charged. We will be pleased to discuss specific financial arrangements prior to initiation of treatment. Any insurance benefits reflect a contractual relationship between the insured and the insurance company, and not the doctor. We are not liable for an insurance company action or any rejected fees. However, we will attempt to utilize the insurance benefits on your behalf in the best way possible. Any treatment plan and fees may be subject to modification after commencement. ____________ Initial

INFORMED CONSENT

As a patient, you have the right at each visit to be informed of your condition. You are entitled to be informed of the recommended dental/surgical procedures available to correct the condition as well as the possible consequences of not treating it at all. After having this information and having been told the risks involved, it is your decision whether or not to undergo these procedures. The doctor will explain to you the dental procedures he is suggesting. You will have the opportunity to ask questions about them and he will answer them to your satisfaction before proceeding. Success in this treatment will depend greatly upon your general health, diet, oral hygiene and expectations. As in any health profession, no guarantees can be made because of the complexities of your condition. We will, however, attempt to provide the most beneficial service possible within the limitations you present. ____________ Initial