

HEALTH HISTORY & REGISTRATION

PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City: _____ State / Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc Sec: _____
E-mail: _____ I would like to receive correspondences via e-mail.
Patient Is: Policy Holder Preferred Name: _____
Responsible Party Who May We Thank for Referring You To our Office? _____

RESPONSIBLE PARTY

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ Address 2: _____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____
Birth Date: _____ Soc Sec: _____ E-mail: _____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc Sec: _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
Insured Soc Sec: _____ Insured Birth Date: _____
Employer: _____ Insurance Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

CONSENT The undersigned hereby authorizes the 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 and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all dental insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balances. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____