

PATIENT REGISTRATION

Patient Information

Account No. _____

Patient's Last Name		First Name	Middle Initial	Social Security #
Nickname	Sex	Birthdate (Mo., Day, Year)	Number of Brothers	Number of Sisters
Street Address		City, State, Zip Code		(Area Code) Home Phone

Father's Information

Father's Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Father's Social Security #	Father's Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#		Email	

Mother's Information

Mother's Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Mother's Social Security #	Mother's Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#		Email	

Step Parent, Guardian or Other Insurance Carrier

Last Name		First Name	Middle Initial	Birthdate (Mo., Day, Year)
Street Address (If different than patient)		City, State, Zip Code		(Area Code) Home Phone #
Employed By	Job Position	Business Address		(Area Code) Cell Phone #
Social Security #	Dental Insurance			(Area Code) Business Phone #
Group #	Insurance ID#		Email	
Relationship to Patient				

Emergency Information

Person to be reached in case of emergency, other than parent:

Name	Relationship to Patient	(Area Code)Phone Number
Name	Relationship to Patient	(Area Code)Phone Number

Consent For Treatment Of A Minor

Because your child is a minor, signed permission is required from a parent or legal guardian before any dental services can be rendered. By signing your consent below, you are giving the Doctors permission to perform a dental examination including x-rays (periapical, bitewing, occlusal, panoramic, and/or cephalometric, radiographic films), photographs, and/or models. This authorization also includes all necessary treatment, medications and therapy indicated for the dental care of your child, including local anesthetic and nitrous oxide analgesia as indicated by the doctor. The doctors are also given permission to use their professional judgement in patient management regimes as they feel necessary.

I understand that, at any time, I have questions I may speak to the doctor treating my child. I understand I can ask questions until I have received satisfactory answers to those questions.

I authorize release of information to my insurance carrier. I authorize payment directly to the doctor from my insurance carrier.

I understand and agree that, (regardless of my insurance status), I am responsible for the balance on my account at the time professional services are rendered. I understand it is my responsibility to pay all fees not covered by my insurance. I understand it is my responsibility to pay all costs associated with collection of unpaid and overdue balances including the costs associated with collection agencies should such action be indicated. I have read all of the information and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes. I certify by signing this, I am the minor's legal parent or guardian.

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

DENTAL ASSISTANT _____