REGISTRATION

PATIENT INFORMATION

Last Name_________________________________ First ____________________ MI __________

Nickname__________________________ Birth Date ___________ Age _____ Sex _________

Home Address ____

City-State-Zip ____

Home Phone: ____________________ Work Phone: _________________ Cell/Pager: ____________

Social Security # ____________________________ Driver's License # _____________________

Employer ____________________ Address __________________________ Occupation ____________

E-Mail ___________________________________ May we e-mail messages to you? ________________

REFERRED BY: ____

Spouse's Name ____

Spouse's Employer ______________________________________ Occupation ____________________

Work Phone ____________________ Social Security # ____________________ Birth Date ___________

ACCOUNT INFORMATION

Person Responsible for Account (If different than patient):

Last Name ________________________________ First ____________________________ MI ________

Relationship to Patient _______________________ Birth Date ______________ Age ________ Sex _______

Home Address ____

Social Security #: __________________________________ Driver's License #: _____________________

Home Phone ______________________________________ Work Phone _________________________

Employer ____ Occupation __________________________

Employer's Address ____

I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also authorize release of any information concerning my (or my child's) health care, medical history, advice and treatment to another dentist of if applicable, an insurance company. Since appointment times are reserved exclusively for me, I understand that charges may occur if I give less than 24 hours notice of an appointment change or cancellation.

Signature ____ Date _______________________________