PATIENT REGISTRATION

Date: _____

Child's
Last Name _____ First Name _____ MI____ Birth Date_____

◯ Male ◯ Female

Parent's/Guardian's

Last Name _____ First Name _____ MI____

Street address _____City _____State____ Zip_____

How did you hear about our office?

Circle choices which apply.

- Insurance company
- Friend (name)_____
- Internet Search
- Armed Forces Directory
- Medical Doctor or Dentist
- Other

What is the reason for today's visit? _____

Previous dentist's name and location: _____

Who is financially responsible for this account? _____

Street address _____City _____State____ Zip_____

Contact information:

What is the preferred method to contact you?
Check off

Home Phone	
Cell Phone	
e-Mail	
Other phone/e-mail	

Authorizations:

I certify that the above information is correct. I hereby authorize my insurance benefits to be paid directly to the dentist and I am financially responsible for non-covered services. I also authorize the dentist to release information as required for collections. In the event my account becomes delinquent, I understand that I am responsible to pay actual and reasonable collection charges and/or interest up to 18% per annum (1.5% per month) and/or attorney fees.

I understand that the cancellation policy for appointments requires 48 hour notice or there will be a $25.00 charge.

X_____ X_____

Parent/Guardian Signature Printed Name