Patient Registration Information

Welcome to our practice!

Date _____

Name:_____ Birthdate:_____

Home Address:_____

City:_____State:_____Zip:_____ Cell #: _____

Home Phone:_____Social Security #:_____

Employer:_____Work Phone:_____

Email Address: _____

Spouse's
Name:_____Birthdate:_____Cell#:_____

Spouse's Employer:_____

Spouse's Social Security #:_____

Who is responsible for this account:_____

Person to contact in case of an emergency:_____Phone:_____

Who may we thank for referring you?_____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and /or other health practitioners.

All accounts over 30 days will be subject to 1.8% -month finance charge. In case of default on payment of my account or my spouse's account, I agree to pay collection cost (50%) and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Signature:_____Date:_____