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PATIENT REGISTRATION FORM

Patient's Name_____ SS#_____

Sex: ☐ Male ☐ Female Date of Birth: _____

Address: _____ City_____ State_____ Zip_____

Telephone: Home _____Work _____ Cell_____ Email_____

Occupation_____

Employer_____ Employer's address_____ City _____ State_____

Whom may we thank for referring you to our office _____?

Person to contact in case of emergency_____ Relationship_____ Phone number_____

Method of payment: Insurance_____ Cash_____

The complete dental need of a patient cannot be known until there has been a full diagnosis including x-rays & examination. Emergency care must be paid at the time of services. When the diagnosis is complete the patient and the doctor will discuss the services needed. All financial arrangements must be done before any work is performed. Our office manager will evaluate all insurance plans and arrange all payment methods with you. Our office operates on a strict appointment schedule in order to maximize the time spent on quality dental care. Hence, we require a 24-hour advance notice for all cancellations. Please call ahead if you will be late for the appointment. 30 minutes late is considered a cancellation without notice. By signing below, you are responsible for the accuracy of all information you provided and agree to the rules and regulations of this office.

Thank you.

Signature_____ Date_____