PATIENT REGISTRATION HISTORY

Patient Name: Mr. Mrs. Miss_____ Date: _____

Home Address: _____ City_____ State_____ Zip_____

Home Phone: (____)_____ Work Phone: (____)_____Cell Phone: (____)_____

Soc. Sec. # _____Birth Date: _____Driver License #: _____

Occupation:_____ Single_____Married_____Divorced_____Widowed_____

Email: _____ If child, parent/guardian's full name: _____

Person financially responsible: _____ Relationship to you_____ SS#_____

Person to contact in case of an emergency _____ Phone # _____

Primary Dental Insurance: _____Group#_____ ID#_____

Insured Name _____ Insured Date of Birth_____

Employer Name and Address: _____

Secondary Dental Insurance: _____Group#_____ID#_____

Insured Name _____ Insured Date of Birth_____

Employer Name and Address: _____

Spouse's Name: _____ Birth date: _____ SS# _____

REFFERAL _____ WALK IN____ NEWSPAPER AD____ VALPAK___

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I consent to the administration of local anesthesia (Novocain) in connection to all dental procedures as needed. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to pain, swelling, bruising, hematoma, cardiac stimulation, muscle soreness, temporary or rarely permanent abnormal sensation or taste, temporary or rarely permanent numbness, and rarely life threatening reactions. We ask that your estimated portion, or payment in full, be paid at the time services are rendered. As a service to you, our office will process all insurance claims. Should a situation arise that your insurance company will not cover a rendered service; the person responsible for the account will be held liable for the account balance. I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I certify that the information on this page is correct to the best of my knowledge.

X _____ _____

PAIENT/GUARDIAN SIGNATURE DATE