# PATIENT REGISTRATION

DATE

## PATIENT INFORMATION

| LAST NAME | FIRST | MI |
|---|---|---|
| PREFERRED NAME | | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| HOME PHONE NO. | WORK NO. | CELL NO. |
| BIRTHDATE | SOCIAL SECURITY NO. | |
| MALE FEMALE MARRIED SINGLE DIVORCED | | |
| E-MAIL ADDRESS | | |

| EMERGENCY CONTACT | PHONE NO. |
|---|---|
| CLOSEST RELATIVE NOT LIVING WITH YOU | |
| PHONE NO. | |
| CITY STATE ZIP | |

## MISCELLANEOUS INFORMATION

HOW WERE YOU REFERRED? **PLEASE CIRCLE ALL THAT APPLY**

BILLBOARD PHONE BOOK INSURANCE WEBSITE

RIVERVIEW WEBSITE DRIVE-BY GOOGLE SEARCH

FRIEND/RELATIVE/OTHER:_____

## PERSON FINANCIALLY RESPONSIBLE

| LAST NAME | FIRST | MI |
|---|---|---|
| ADDRESS | | |
| CITY | STATE | ZIP |
| HOME PHONE NO. | WORK NO. | CELL NO. |
| BIRTHDATE | SOCIAL SECURITY NO. | |

## YOU

| EMPLOYER | OCCUPATION |
|---|---|
| EMPLOYER PHONE | |

## YOUR SPOUSE

| NAME | OCCUPATION |
|---|---|
| EMPLOYER NAME | EMPLOYER PHONE |

## CONSENT FOR TREATMENT

I hereby authorize doctor or desgnated staff to take xrays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (or my dependent's) dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary . I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

## FINANCIAL AGREEMENT

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. I understand and agree that due to constantly changing benefit plan terms, benefits expected are only an estimate and that, regardless of my benefit plan, I am responsible for payment of all services. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____Date_____

Parent/Responsible Pary Signature_____Relationship to Patient_____