

# PATIENT REGISTRATION

DATE
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## PATIENT INFORMATION

LAST NAME	FIRST	MI		
PREFERS TO BE CALLED BY				
ADDRESS				
CITY	STATE	ZIP		
HOME PHONE NO.	WORK NO.	CELL NO.		
MAY WE CONFIRM YOUR APPT VIA TEXT?		YES NO		
BIRTHDATE	SOCIAL SECURITY NO.			
MALE	FEMALE	MARRIED	SINGLE	DIVORCED
E-MAIL ADDRESS				

## DENTAL INSURANCE INFORMATION PRIMARY DENTAL INSURANCE

INSURANCE COMPANY	GROUP NO.
EMPLOYER NAME	
INSURED'S NAME	INSURED'S DATE OF BIRTH
INSURED'S ID NO.	
INSURED'S SOCIAL SECURITY NO.	

## SECONDARY DENTAL INSURANCE

INSURANCE COMPANY	GROUP NO.
EMPLOYER NAME	
INSURED'S NAME	INSURED'S DATE OF BIRTH
INSURED'S ID NO.	
INSURED'S SOCIAL SECURITY NO.	

## PERSON FINANCIALLY RESPONSIBLE

LAST NAME	FIRST	MI
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	WORK NO.	CELL NO.

## MISCELLANEOUS INFORMATION

HOW WERE YOU REFERRED? PLEASE CIRCLE ALL THAT APPLY.			
BILLBOARD	PHONE BOOK	WEBSITE	DRIVE-BY
FRIEND/RELATIVE/OTHER: _____			

## YOU

EMPLOYER	OCCUPATION
EMPLOYER PHONE	

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

## YOUR SPOUSE

EMPLOYER	OCCUPATION
EMPLOYER PHONE	

## CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take xrays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed up 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.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations.

I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that I have received a copy of Riverview Dental's privacy practices outlining the protection of my personal health information.

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.

In the event payments are not received by agreed upon dates, I understand that a 1½% 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 Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_