WELCOME

Age_____ Date of Birth_____ □ Male □ Female

Patient's Name _____ Today's Date _____
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed_____
Single □ Married □ Separated □
Divorced □ Widowed □ Minor □

Home Address_____

City_____ State_____ Zip_____

Telephone: Home_____

Bus._____ Cell Phone_____

Email _____

Patient/Parent Employed by_____

Present Position_____

Spouse/Parent Name_____

Spouse/Parent Employed by _____

Present Position_____

Who is Responsible for this account _____

Drivers License No. _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral_____

Patient/Parent Social Security No._____

Spouse/Parent Social Security No. _____

Someone to notify, in case of an emergency, not living with you_____

---------- DENTAL INSURANCE

Employee Name_____ Date of Birth_____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Insurance Address_____

_____

Insurance Telephone No._____

Program or Policy No. _____

Subscriber Social Security No. _____

Group No. _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to Dr. Barnes and the staff's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following person(s) who is/are involved in my care (or my child's care) or payment for that care.
Person(s) Name_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, by my dental care payer (insurance).

I attest to the accuracy of information on this page.

Patient's/Guardian's Signature_____

Date _____

REGISTRATION