Patient Registration

Patient Name

Medical Alert

Date

Last Name | First Name | M.I.

Prefers to be called by

Address

City | State | Zip

Home Phone | Fax

Cell | Email

Birthdate Age | Male ☐ | Female ☐

Married ☐ | Single ☐ | Divorced ☐ | Widowed ☐

Social Security No.

Fill in the area below for your child. Use another sheet if necessary.

Date

Last Name | First Name | M.I.

Prefers to be called by

Address

City | State | Zip

Home Phone | Fax

Cell | Email

Birthdate | Age | Male ☐ | Female ☐

Married ☐ | Single ☐ | Divorced ☐ | Widowed ☐

Social Security No.

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Group No.

Employer Name

Insured's Name

Date of Birth | Relationship To Patient

ID No

Insured's Social Security No.

SECONDARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Date of Birth | Relationship To Patient

ID No

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Relationship to Patient | Social Security No.

Address

City | State | Zip

Phone No.

YOU

Name

Occupation

Employer's Name

Address | City

Phone | Fax

YOUR SPOUSE

Name

Occupation

Employers Name

Address | City

Phone | Fax

GETTING TO KNOW YOU

Is another member of your familly or relative a patient at our office?

Name:

Relationship:

You were referred to us by

Name:

Person to contact for emergency

Name:

Cell:

Home:

Address:

DR. HATEM DDS

Please turn over and sign.

Consent for Treatment

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

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. 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.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral written or electronic health records that are 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 a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due a 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 late charge may be added to my account. If required, I also understand that a check of my credit history may be made.

6. Cell Phone Number_____

I consent to the dental practice using my cell phone to ☐ call or ☐ text regarding appointments and to call regarding treatment, my insurance and my account. I understand that I can withdraw my consent at any time.

Patient's Signature_____Date_____

Parent/Responsible Party Signature_____

Relationship to Patient_____