Patient Registration | Date: __________

Please fill out if this appointment is for you:

Last name: ______________ First: ________________
M.I. ________
Prefers to be called by: ________________
Address: ______________________________
City: ______________ State: ______ Zip: ________
Home No.: ______________ Fax: ____________
Cell No.: ________________ Email: ____________
Birthdate: __________ Age: _____ ☐Male ☐Female
☐Married ☐Single ☐Divorced ☐Widowed
Social Security No.: ___________

Please fill out if this appointment is for your child:

Last name: ______________ First: ________________
M.I. ________
Address: ______________________________
City: ______________ State: ______ Zip: __________
Home Phone No.: ______________________
Birthdate: __________ Age: _____ ☐Male ☐Female
School: ______________________ Grade: ________
Social Security No.: ____________________
If your child's last name and/or address are not the same as yours, please indicate on the left side also.

Primary Carrier:

Insurance Company: ______________________
Group No.: ______________________
Employer Name: ______________________
Insured's Name: __________ Date of birth: _________
Relationship to patient: ______________________
Insured's ID No.: ______________________
Insured's SS#: ______________________

Secondary Carrier:

Insurance Company: ______________________
Group No.: ______________________
Employer Name: ______________________
Insured's Name: __________ Date of birth: _________
Relationship to patient: ______________________
Insured's ID No.: ______________________
Insured's SS#: ______________________

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?
Name: ______________________ Relationship: ______________________
You were referred to us by:
Name: ______________________
Person to contact for emergency
Name: ______________________ Cell No.: ______________________ Home No.: ________________
Address: ______________________ City: ______________________ State: ______ Zip: ____________

ACCOUNT INFORMATION

Person financially responsible for account
Name: ______________________ Relationship to patient: ______________________
Address: ______________________ City: ________________ State: __________ Zip: ____________
SS#: ______________________ Phone No.: ____________________________
You
Name: ______________________ Occupation: __________ Employer's name: ________________
Address: ______________________ City: ____________ Phone No.: __________ Fax No.: ___________
Your spouse
Name: ______________________ Occupation: __________ Employer's name: ________________
Address: ______________________ City: ____________ Phone No.: __________ Fax No.: ___________

CONSENT FOR TREATMENT

l. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Zachery Green to make a thorough diagnosis of (name of patient) ‘s ______________________________dental needs.

2. Upon such diagnosis, I authorize Dr. Zachery Green 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 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 nececessary 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 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 1-1 /2% 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 ____________ Witness _________________

Parent/Responsible Party’s Signature______________ Relationship to Patient ______________________