TWIN BUTTES **DENTAL**
GENERAL & ESTHETIC DENTISTRY

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.: _____

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CONSENT FOR TREATMENT

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

2. Upon such diagnosis, I authorize Dr. Max Wahoske 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_____

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