PATIENT REGISTRATION

Last Name_____ First: _____

Preferred: _____

DATE: _____/_____/____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

City: _____ State: _____ Email:_____

Birthday: _____ / _____ / _____ Married _____ Single _____ Divorced _____ Widowed _____

Social Security # _____ - _____ - _____ Employer's Name: _____

Employer's Address: _____ City: _____

Occupation: _____

When is the best time to reach you? Morning ____ Afternoon_____ Evening _____ Anytime _____

How would you like to be contacted? (List in order of preference) Home ____Work ____Cell ____Text ____E-Mail ____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Email: _____

Spouse's Cell / Emergency Contact Number: _____

Person financially responsible for the account: If self, check here: _____

If someone other than yourself will be responsible for this account please complete below:

Name: _____ Relationship to patient: _____

Social Security # of responsible party: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Whom can we thank for referring you to Rolling Hills Dental? _____

If not referred, how did you hear about our office? Internet ____ Other (describe) _____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the 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 anesthetic 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 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 ½% late charge per month (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

5. I understand that if I must cancel my appointment, notice of this cancellation must be given during business hours at least one weekday (Monday – Friday) in advance, to a staff member or doctor to avoid a charge to my account. Charges for missed or canceled appointments will be determined by the doctor.

Patient's Signature _____ Date: ____ / ____/ _____ Witness _____

Patient's Responsible Party's Signature _____ Relationship: _____