PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Parent's Name (if child): _____
(First) (M.I.) (Last)

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

Home Phone: _____ Work Phone: _____

- may we call on this phone: ☐ Yes ☐ No **- may we call on this phone: ☐ Yes ☐ No**

Cell Phone: _____ Email Address: _____

- may we call on this phone: ☐ Yes ☐ No

Birth Date: _____ Sex (M/F): _____ Social Sec. #: _____

Place of Employment: _____

Work Address: _____

Marital Status: _____ Spouse's Name: _____

Referred by: _____ Reason for Today's Visit: _____

Person to contact in case of emergency: _____ Phone: _____

DENTAL INSURANCE INFORMATION

As a courtesy to you, we do our best to facilitate your insurance claims. However, we are not agents of your insurance company. Your insurance benefits are a contract between you and your insurance company.

Name of insured: _____ Relationship to patient: _____

Insured's Social Sec. #: _____ Insured's Birth date: _____

Insured's employer: _____ Insurance company phone: _____

Insurance company: _____ Group #: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Do you have a secondary dental insurance? ☐ NO ☐ YES If YES, complete the following:

Name of insured: _____ Relationship to patient: _____

Insured's Social Sec. #: _____ Insured's Birth date: _____

Insured's employer: _____ Insurance company phone: _____

Insurance company: _____ Group #: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes Dr. Rados to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Rados to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Rados to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Rados choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I also assign all insurance benefits to Dr. Rados and authorize the release of any medical or other information necessary to process the claims. Any payments received by Dr. Rados from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

_____ _____

SIGNATURE OF PATIENT (OR PARENT IF MINOR) **DATE**