Patient Registration

Patient Information

___ Mr. ___ Mrs. ___ Ms. ___ Dr. Name _____
First M.I. Last

Male ___ Female ___ Date of Birth _____ I prefer to be called _____
Referred by _____
Home Address _____ Home Phone _____
_____ Work Phone _____
Email Address _____ Cell Phone _____
**Do not include any phone numbers that you do not wish us to use.*
Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Spouse/Partner/Parent/Guardian Information (if applicable)

Name _____ Date of Birth _____
Employer _____ Phone _____

Account Information

Person Responsible for Payment _____ Relationship _____
Address _____ Phone _____
_____
Dental Insurance Company _____ Subscriber Name_____

Subscriber Employer_____ Subscriber Date of Birth _____

I understand that payment is due in full at the time services are rendered. We will file your insurance today electronically as a courtesy to you and reimbursement from your insurance company will come directly to you. Note: We are NOT In-Network with any insurance company. Please provide dental insurance card so that we may make a copy.

Dental History

When was your last dental exam or cleaning? _____
Do you take an antibiotic pre-medication before dental procedures? _____
Have you ever had an unusual reaction to a dental procedure? If so, explain:

_____
What is your primary dental concern today?

_____

To the best of my knowledge, the questions on this form and all other forms have been accurately answered. I understand that it is my responsibility to update Drs. Jackson/Samuelson and her staff on any changes to my Patient Information, Account Information, and Medical/Dental status. I authorize Drs. Jackson/Samuelson and/or her staff to provide dental treatment to me that is mutually agreed upon and I acknowledge that treatment procedures are explained prior to services being rendered.

Signature _____ Date _____

Signature of Responsible Party, if other than patient _____