PATIENT HEALTH RECORD

Welcome to our office. Please help us by filling out this form as accurately as you can. THANK YOU.

Patient's Name			Date
How do you wish to be addressed?			Date of Birth
Residence/Street			Patient Social Security No.
City	State	Zip	Phone/Residence

If Child, Parent's Name	Social Security No.
Patient / Parent Employed by	Phone/Business
Spouse / Parent Name	Social Security No.
Spouse Employed by	Phone/Business
If different from above, Spouse/Parent Address	Phone/Residence
Who is Responsible for this Account?	
Do you have Dental Insurance? Yes ☐ No ☐	Name of Plan
Someone to Notify in case of Emergency, not living with you. Name:	Phone

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and adminsitering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advise and treatment to another dentist.

I understand that I am responsible for all costs of dental treatment.

I hereby authorize payment of insurance benefits directly to the dentist or otherwise payable to me.

I attest to the accuracy of the information on this page.

Patient or Guardian's Signature ______________________ **Date** __________

REGISTRATION