TODAY'S DATE _____

PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME MIDDLE INITIAL LAST NAME			NICKNAME OR PREFERRED NAME
EMAIL			
ADDRESS			BIRTHDATE
CITY STATE ZIP			☐ MALE ☐ MARRIED ☐ FEMALE ☐ SINGLE
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER

IF PATIENT IS A MINOR, PROVIDE THE FOLLOWING	PARENT/LEGAL GUARDIAN FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT ☐ PARENT ☐ GRANDPARENT ☐ OTHER ☐ LEGAL GUARDIAN	
	EMAIL ADDRESS			
	ADDRESS ☐ SAME AS ABOVE	CITY	STATE	ZIP
HOME PHONE ☐ PREFERRED	CELL PHONE ☐ PREFERRED	WORK PHONE ☐ PREFERRED	SOCIAL SECURITY NUMBER	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER (PLEASE SPECIFY)_____				

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE THE FOLLOWING & YOUR INSURANCE CARD

PRIMARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER

INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
PRIMARY INSURED NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED INSURANCE I.D. NUMBER	GROUP NUMBER
INSURED SOCIAL SECURITY	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

Acknowledgement of Financial Responsibility: 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. This is including deductibles, co-pays, and any estimated portion insurance is not covering. I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Elison Dental Center. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Elison Dental Center. In the event payments are not received by agreed upon dates, I understand that a $25 charge per late payment may be added to my account. I further agree to inform Elison Dental Center of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Elison Dental Center to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

Notice of Privacy Practices: I acknowledge that I have received the Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Consent for treatment: I hear by authorize the doctor or designated staff to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon 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. I agree to use of anesthetics, sedatives, and any other medication as necessary. I understand I can ask for a complete recital of any possible risk of complications.

Office policies: The office is open Monday-Thursday from 8:00am-5:00 pm, and every other Friday 8-12:00 pm. We require a 24-hour notice if you need to cancel/reschedule an appointment. Anyone late 15 minutes for an appointment will not be seen that day and we reserve the right to charge a fee. We guarantee all dental work for 2 years completed in our office and crowns for 5 years if not tempered with in another office. The only requirement is that you visit every six months for checkup and cleaning.

Final Signature: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elison Dental Center or insurance company to release any information required to process my claims.

_____

Patient Signature Date

_____

Parent/Responsible Party Signature Date