Penniall
family dental

REGISTRATION FORM

Today's Date_____

Patient Information

Name_____Date of Birth_____
Address_____Apt. No._____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Cell Phone_____Email Address_____
Male_____Female_____Marital Status_____
Social Security_____Driver's License No._____
Person to contact in case of emergency_____

Responsible Party Information

Name_____Relationship to Patient_____
Address_____Apt. No_____
City_____State_____Zip_____
Home Phone_____Work Phone_____
Social Security No._____Driver's License No._____
Person to contact in case of emergency_____

Insurance Information

Employee Name_____Employer Name_____
Insurance Company_____Group Number_____
Employee Date of Birth_____Employee Social Security_____

Who may we thank for referring you to our office?_____

I hereby authorize doctor or designated staff to take x-rays, study models, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient)_____'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedative 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.

Patient or Responsible Party_____Date_____