PATIENT REGISTRATION

Please complete the following confidential information in full for optimum understanding of your dental wishes and desires. Everyone has individual needs, so we want to give you personal attention to assure you the most comfortable dental experience as possible.

Date	
Patient Name	
Address	
City	**State** **Zip**
Best way to contact you: H W C	**Phone Email Text Message**
Home Phone No.	
Work Phone No.	
Cellular Phone No.	
E-mail Address	
Birth date	**Age** **Male ☐ Female ☐**
Social Security Number	
Married ☐	**Single ☐** **Divorced ☐** **Widowed ☐**
Employer	
School	

Responsible Party
Address
City
Responsible Party Social Security Number

DENTAL INSURANCE
PRIMARY DENTAL CARRIER
Insurance Co.
Subscriber Birth date
Subscriber
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

SECONDARY DENTAL CARRIER
Insurance Co.
Subscriber
Subscriber Birth Date
Subscriber Employer
Subscriber Union or Local
Subscriber Social Security No.

The best time for you for appointments are at: _____ AM/PM

The best day of the week is: M T W TH
(Circle one or more)

_____

Who may we thank for referring you: _____

_____

☐ Friend's Name _____
☐ Sign _____
☐ Website/Internet Search _____
☐ Flyer _____
☐ 1-800 Dentist
☐ Newsletter _____
☐ Radio _____
☐ Newsletter _____

Emergency Contact Information

Name _____
Relationship _____
Phone No. _____
Address _____
City _____State _____Zip_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____ 's dental needs.
(name of patient)

2. Upon such diagnosis, I authorize doctor perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, 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. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Date

Parent of Minor Relationship

CRYSTAL LAKE
DENTAL ASSOCIATES

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