Patient Registration

PATIENT NAME (FIRST, MI, LAST) ______ BIRTH DATE ___/___/______

ADDRESS ______ CITY ______ STATE ___ ZIP ______

MARITAL STATUS: ◯ Single ◯ Married ◯ Widowed ◯ Divorced EMAIL ______

HOME PHONE ______ CELL PHONE ______

WORK PHONE ______ EMPLOYER ______

PERSON RESPONSIBLE FOR ACCOUNT ______ RELATIONSHIP ______

PERSON RESPONSIBLE PHONE ______ PERSON RESPONSIBLE EMAIL ______

PERSON TO NOTIFY IN AN EMERGENCY ______ RELATIONSHIP ______

EMERGENCY PERSON PHONE ______ EMERGENCY PERSON EMAIL ______

HOW DID YOU HEAR ABOUT OUR OFFICE? ______

CONSENT

Ⓨ Ⓝ May we leave a message on voicemail or an answering machine regarding treatment, appointments, or billing?

Ⓨ Ⓝ May we give information regarding your treatment, appointments, or discussion of billing with anyone other than yourself? If so, complete below:

INFORMED PERSON NAME ______ RELATIONSHIP ______

AUTHORIZATION

I hereby authorize the doctor to perform any forms of treatment, medication, and therapy which may be deemed necessary. I also understand that before treatment, the doctor and/or staff will give full explanation of the procedure(s) involved. I agree to pay for services rendered by this dental practice regardless of insurance.

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) ______ DATE ___/___/______

PRIMARY DENTAL INSURANCE INFORMATION

NAME OF INSURED ______ BIRTH DATE OF INSURED ___/___/______

RELATIONSHIP TO PATIENT: ◯ Self ◯ Husband ◯ Wife ◯ Mother ◯ Father ◯ Partner ◯ Other ______

EMPLOYER ______ EMPLOYER PHONE ______

INSURANCE ______ INSURANCE PHONE ______

INSURED SOCIAL SECURITY NUMBER ______ EMPLOYEE ID ______ GROUP ID ______

SECONDARY DENTAL INSURANCE INFORMATION

NAME OF INSURED ______ BIRTH DATE OF INSURED ___/___/______

RELATIONSHIP TO PATIENT: ◯ Self ◯ Husband ◯ Wife ◯ Mother ◯ Father ◯ Partner ◯ Other ______

EMPLOYER ______ EMPLOYER PHONE ______

INSURANCE ______ INSURANCE PHONE ______

INSURED SOCIAL SECURITY NUMBER ______ EMPLOYEE ID ______ GROUP ID ______

ACKNOWLEDGMENT

I understand that as a courtesy to me, Dr. Monte Morgan's office will assist me in processing my insurance claims. However, I understand that **I am completely responsible for all fees**. I also understand that 48 hour notice is required for all appointment changes or a fee will be charged.

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) ______ DATE ___/___/______