

# Patient Registration

Please complete the following confidential information.

DATE \_\_\_\_\_

LAST NAME FIRST M.I. \_\_\_\_\_

PREFER TO BE CALLED \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE FAX \_\_\_\_\_

CELL PHONE EMAIL \_\_\_\_\_

BIRTHDATE AGE \_\_\_\_\_

CIRCLE ONE: MARRIED SINGLE DIVORCED WIDOWED \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE FAX # \_\_\_\_\_

## ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT IF DIFFERENT FROM ABOVE NAME \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

**SPOUSE**

NAME \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE # FAX # \_\_\_\_\_

## DENTAL INSURANCE

**PRIMARY CARRIER:**

INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

INSURED'S ID # \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_

## SECONDARY CARRIER:

INSURANCE COMPANY \_\_\_\_\_

GROUP # \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_

## EMERGENCY CONTACT

NAME \_\_\_\_\_

PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

**CLOSEST RELATIVE NOT LIVING WITH YOU**

NAME \_\_\_\_\_

PHONE # \_\_\_\_\_

ADDRESS, CITY \_\_\_\_\_

Please turn over and sign.



Felines H. Tipton, DDS

## CANCELLATION / FAILED APPOINTMENT POLICY

I agree to pay \$50. for any failed appointment or appointments cancelled without 24 hours notice.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/responsible party's signature \_\_\_\_\_ Date \_\_\_\_\_

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## CONSENT FOR TREATMENT

1. I hereby authorize Dr. Tipton or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (patient's name) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed on 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 I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's and designated staff's use and disclosure of any oral, written or electronic health records individually identifiable as mine, for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality dental care will be used or disclosed, and that a "Privacy Policy" statement that outlines protection of my private health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependant's. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. I also understand a check of my credit history may be made if required.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Parent/responsible party's signature \_\_\_\_\_ Date \_\_\_\_\_



**Felines H. Tipton, DDS**