REGISTRATION FORM

Date:_____

First Name:_____Last Name:_____

Patient is: ☐ Policy Holder ☐ Responsible Party Referred by:_____

Patient Information

Address:_____City:_____State/Zip:_____

☐ Home # ( )_____ ☐ Work # ( )_____ext._____

☐ E-Mail:_____ ☐ Cell # ( )_____

Birth Date:_____SS#_____Driver's License #_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party

First Name:_____Last Name:_____

Address:_____City:_____State/Zip:_____

☐ Home # ( )_____ ☐ Work # ( )_____ext._____

☐ E-Mail:_____ ☐ Cell # ( )_____

Birth Date:_____SS#_____Driver's License #_____

☐ Responsible party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Policy Holder

Primary Insurance Information

Name:_____

SS#_____D.O.B._____

Employer:_____

Ins. Company:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Information

Name:_____

SS#_____D.O.B._____

Employer:_____

Ins. Company:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor chooses and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for my dependants or myself is mine, due and payable at the time services are rendered unless other arrangements have been made.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
7. I authorize the use of my social security number to file my dental claim.
8. I grant to Ferrari Dental, its representatives and employees the right to take photographs of me. I authorize Ferrari Dental to use and publish the photos in print and /or electronically. I agree that Ferrari Dental may use such photos of me with or without my name for any lawful purpose, including for example publicity, illustration, advertising and Web content.

I have read and understood the above.

Parent/Guardian Signature:_____ Date:_____