PATIENT REGISTRATION

TODAY'S DATE
WHO MAY WE THANK FOR YOUR REFERRAL?
WHAT IS YOUR RELATIONSHIP WITH THIS REFERRAL?

YOUR NAME	SPOUSE'S NAME
BIRTHDAY	BIRTHDAY
S.S. #	S.S. #
MALE ❑ FEMALE ❑	MALE ❑ FEMALE ❑
MARITAL STATUS	MARITAL STATUS
CELL PHONE	CELL PHONE
HOME PHONE	HOME PHONE
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
E-MAIL ADDRESS	E-MAIL ADDRESS
OCCUPATION	OCCUPATION
EMPLOYER	EMPLOYER
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP
BUS. PHONE	BUS. PHONE

LIST CHILDREN IN THE FAMILY

NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE
NAME	BIRTHDATE

EMERGENCY CONTACT PHONE
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 (name of the patient)_____'s dental needs.
2. Upon such diagnosis, I authorize doctor to 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 embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I release clinical and restorative dental photos taken by Brent A. Engelberg, D.D.S., P.C. and I understand that photos may be used by Brent A. Engelberg, D.D.S., P.C. for teaching, publications, and for patient education.
5. Lastly, I understand and agree that any collection or legal fees incurred by Brent A Engelberg, D.D.S., P.C., in an effort to collect debts I owe, will be my responsibility.

Patient _____ Date _____ Witness _____

Patient or Responsible Party_____ Relationship to patient _____