## 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 confirm / remind appointments:** Text E-mail Phone HWC |
| Home Phone No. |
| Work Phone No. |
| Cellular Phone No. |
| E-mail Address |
| Birth date Age Male □ Female □ |
| Married□ Single□ Widowed□ Divorced□ |
| Employer Position |
| School |

| |
|---|
| Responsible Party (if different than patient) |
| Address |
| City State Zip |
| Phone 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 make we thank for your referring you:** |
| □ Friend's Name |
| □ Website / Internet Search |
| □ Facebook |
| □ Street Sign |
| □ Television |
| □ Other |
| **Emergency Contact Information:** |
| Name |
| Relationship |
| Phone Number |
| Address |
| City State Zip |

### CONSENT FOR TREATMENT

1. I hereby authorize Dr. Barr 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 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 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 unless other arrangements have been made. 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 Guardian Relationship