

# Welcome to our office

# Patient Registration

We appreciate the opportunity to provide excellence to you.

Tell Us About The Patient			
Name			
Mailing Address			
City			
State		Zip	
Email Address			
Home Phone ( ) -			
Cell Phone ( ) -			
Work Phone ( ) -			
Birthdate			
Social Security Number			
Employer			
Employer Address			
Employer City			
Employer Phone			
Spouse's Name			
Gender	Male	Female	

Insured/Responsible Party			
Name			
Mailing Address			
City			
State		Zip	
Email Address			
Home Phone ( ) -			
Cell Phone ( ) -			
Work Phone ( ) -			
Birthdate			
Social Security Number			
Employer			
Employer Address			
Employer City			
Employer Phone			
Spouse's Name			
Relationship to Patient			

If You Have Insurance, Please Fill In This Box			
Primary Insurance		Secondary Insurance	
Insurance Carrier		Insurance Carrier	
Group#		Group#	

Do others in your family come here?

No  
 Yes

Name(s): \_\_\_\_\_

Person to contact for an emergency

Their Telephone ( ) - \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_

How were you referred to our office?  
(please check one)

I have been a patient of the office  
 By another patient/friend (name) \_\_\_\_\_  
 Yellow Pages  
 Saw building/sign  
 By my insurance company  
 By my doctor (name) \_\_\_\_\_  
 Other \_\_\_\_\_

**PLEASE TURN PAGE OVER TO COMPLETE.**

I authorize any doctor or staff to take x-rays, diagnostic models, photographs and other diagnostic aids deemed appropriate to make a diagnosis of the patient's needs. I authorize the doctors and staff to release information for the purposes of diagnosis, treatment, medical evaluation, peer review, educational purposes, billing of charges, legal and collection actions.

I authorize the doctors or staff to perform all mutually agreeable treatments utilizing such assistance as the doctor deems necessary.

I agree to the use of anesthetics or other medications as necessary for my treatment. I fully understand that using medications has certain risks; a full recital of which will be presented if requested.

I understand that I am responsible for all charges incurred for my treatment or for the patient for whom I am the responsible party regardless of any insurance coverage. **Payment for services is due at the time of service. If payment is not received, a finance charge of 1.5% per month (minimum \$.50) may be added to my account for balances older than 120 days.**

**Please indicate your preferred method of payment:**

(We offer monthly payments through DFP that carry low monthly payments, no annual fees, and do not add to your existing credit card balances.)

Cash  
Check  
Credit Card  
DFP Monthly Payments

  
  
  

**Privacy Notice**

I have read this office's Notice of Privacy Practices, a copy of which I may have for my records upon request.  
(also available on website laurel-dental.com)

**Dental Materials Notice**

I have reviewed the State of California DENTAL MATERIALS FACT SHEET as required by law.  
(also available on website laurel-dental.com)

Patient's name (printed please)

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Responsible party's **signature**

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date

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