MYSTIC DENTAL GROUP

PATIENT REGISTRATION

Date: _____

First Name: _____ Last Name: _____

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

Patient Information

Address: _____ City: _____ State/Zip: _____

Hm# ( )_____ Work# ( )_____ ext. _____

Email: _____ Cell# ( )_____

Birth date: _____ SS#: _____ Drivers Lic#: _____

Sex: _____Male _____Female Marital Status: ___Married ___Single ____Divorced ____ Widow

Responsible Party

(For minors only, the guardian which establishes the patient account)

Children under the age of 18 must be accompanied by adult/guardian-children cannot be left unattended. Regarding minors & divorce decrees, we do not split balances and/or keep track of mom/dad's payments.

First Name: _____ Name: _____

Address: _____ City: _____ State/Zip: _____

Hm#: ( )_____ Work # ( )_____ext.____ Cell#: ( )_____

Birth Date: _____ SS#:_____ Drivers Lic#: _____

Parent/Guardian signature: _____ Date: _____

Primary Insurance Information

Name of Insured: _____

Insured ID#: _____ DOB _____

Employer: _____

Ins Co: _____

Relation to patient: __Self __Spouse __Child __ Other

Secondary Insurance Information

Name of Insured: _____

Insured ID#: _____ DOB: _____

Employer: _____

Ins. Co: _____

Relation 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 doctor to make a thorough diagnosis of the patients' s dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the 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 choose 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 myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1% finance charge maybe added to my account, in addition to any collection charges.
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.

Patient/Guardian signature: _____ Date: _____