# PATIENT REGISTRATION

First Name:______________________________Last Name: ___________________Middle______

Preferred Name:_____________________Mr.____Mrs.____Miss____Ms.____Doctor____Other____

Address: ______________________________________________________________________

City, State, Zip:_________________________________________________________________

Home Phone:___________Cell____________Work___________Email Address_____________ ______

Sex: ○ Female ○ Male Marital Status: __ Married__ Single__ Divorced__ Separated__ Widowed___Other____

Birth date:________________Social Security #:________________Drivers Lic#:________________

Employment Status: ○ Full Time ○ Part Time ○ Self Employed ○ Retired ○ Unemployed

Employer__________________________________Address____________________________

Student Status: ○Full Time ○ Part Time Name of School________________________________

Preferred Pharmacy:______________________Address:_____________________________

Referred By:______________________________________________________________

**Emergency Contact**: Name__________________Relationship___________Phone Number__________

**Responsible Party:**

First Name:_____________________Last Name:___________________Middle Initial:__________

Address___________________________________________________________________

City, State, Zip:____________________________________________________________

Home Phone:_________ Cell_____________Work__________Email Address___________________

Date of Birth:___________________Social Security #:_______________Drivers Lic#:_____________

Relationship to Patient:_________________________

**Primary Dental Insurance Information:**

Name of Insured:______________________Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID: _________________________ Carrier (Group) ID:_________________________

Insured Social Security #: __________________Insured Birth date:__________________________

Employer:____________________________Insurance Company:________________________

Address:__________________________City, State, Zip________________________________

**Secondary Dental Insurance Information:**

Name of Insured:______________________________ Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Employer ID:______________________________ Carrier (Group) ID:____________________

Insured Social Security #:________________________ Insured Birth date:__________________

Employer:____________________________ Insurance Company:_______________________

Address:______________________________ City, State, Zip____________________________________

**CONSENT FOR TREATMENT**

- I hereby authorize doctor or designated staff to complete: x-rays, exams, periodontal probings, study models, photography and other diagnostic aids deemed appropriate to make a through diagnosis of (Patient Name)_______________'s dental needs.
- Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and to employ assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary. I full understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- 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.
- I authorize assignment of dental benefits to Avondale Dental (DBA Medure Dental). I understand insurance coverage is only an estimation and I agree to be responsible for all treatment not covered by my dental carrier for myself and dependents.

**Patient Signature**___________________________________ **Date**____________________________

**Patient/Responsible Party**______________________________ **Date**____________________________

**APPOINTMENT AND SCHEDULING POLICY**

- Our practice is dedicated to quality care and exceptional service. We value your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. In return, we ask that you make every effort to arrive on time and keep your reserved dental appointment.
- Late cancellations and missed appointments create scheduling problems for other patients as well as the practice. Keeping this in mind, we ask for a minimum of 48 hours' notice for any appointment changes. A charge may be applied for late cancellations and missed appointments without advanced notice. Thank you for your understanding.

I have read and understand the Appointment and Scheduling Policy

**Patient Signature**_____________________________________________________ **Date**_______________

**Patient/Responsible Party's Signature**_____________________________________ **Date**______________