Nokesville Family Dentistry

PATIENT REGISTRATION

Name: ____ Prefers to be called by: ______________________________
Last First MI

Address: ____
City State Zip

Home Phone: ______________________________ Work Phone: _______________________________ Cell: _____________________________

Email: ____ Marital Status (Circle One): Single Married Divorced Widowed

Social Security Number: _____________________________________ Birthdate: _____________________________ Gender: Male Female

Who may we thank for referring you? Family/Friend________________________Internet____Sign____Other(specify)____________________
Name

Emergency Contact

Name: _____________________________________Relationship:_____________________________Phone Number:__________________________

Name: _____________________________________ Relationship: _____________________________Phone Number:___________________________

Financial Party Information

Name: ____ Relationship to Patient: ___________________________
Last First MI

Address: ____
City State Zip

Phone Number: _______________________________________ Social Security Number: ____

Insurance Information – Please present dental insurance card prior to treatment.

Insurance Company: ____ Employer: ____

Policy Holder's Name: ____ Policy Holder's Birthdate: ____________________________________

Policy Number: ____ Group Number: ____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of 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 agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be rendered to my account. If account is unpaid in 90 days then I understand that collections processing may occur and I may be charged 40% processing fee of the past due balance.
5. **I understand deposits will be requested to reserve future appointments, unless other arrangements have been made. I agree to provide 3 business days' notice if I am unable to keep an appointment and understand that I will be charged a broken appointment fee if the required notice is not provided.**
6. I ____, hereby give my consent to Lauren M. Simon, DDS, to use my dental photographs, video, slides, or any other image, with or without my name, for educational purposes and in the use of promoting aesthetic dentistry.

____ _____________________________________
Patient/Parent Signature Date