PATIENT REGISTRATION AND MEDICAL HISTORY

(Please Print)

Date _____ Home Phone _____

Cell Phone _____

Patient_____
Last Name First Name Initial Preferred Name

Street Address_____

City _____State _____ Zip _____

Sex [ ] Male [ ] Female Age_____ Birth date _____

[ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Employed by _____ Occupation_____

Business Address _____ Business Phone _____

Spouse/ Parent Name_____ Spouse/ Parent Birthday_____

Spouse/ Parent Employed by_____Occupation_____

Business Address_____ Business Phone _____

Who is responsible for this account? _____ Relationship? _____

Social Security #_____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company_____ Group # _____

Whom may we thank for referring you? _____

EMERGENCY CONTACT

Name_____ Relationship_____

Home Phone_____ Work _____ Ext: ____ Cell _____

ASSIGNMENT AND RELASE

I, the undersigned, have insurance with_____ and assign directly to *Vicki L. Tibbs, DDS* all benefits, if any, otherwise payable to me for services rendered. Understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further, authorize the use of this signature on all my insurance submissions.

MINOR/CHILD CONSENT

I being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

FOR DIVORCED OR SEPARATED PARENTS

The parent bringing the child in for treatment will be held responsible by the office for any unpaid portion of the bill. It will be your responsibility to pursue collection if the other parent is held legally responsible for dental fees.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parent/guardians are responsible for all fees for services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I understand that I am to pay my deductible and any co-payments involved on the day of service. I understand that there is a fee of $35.00 for returned checks. I understand that I may be charged $50.00 if I miss a scheduled appointment without a 24 hour Notice. I further understand if I am sent to collection, file bankruptcy or not in compliance with this policy I can be seen on **CASH** basis from that point on or may be dismissed as a patient.

To the best of my knowledge, all of the preceding answers are true and correct.

_____

Date *Signature of Insured/ Guardian/ Patient*