CARPINTERIA SMILES
DENTISTRY

Patient Registration Web Version: CarpinteriaSmiles.com

Thank you for taking the time to complete this patient registration form. The information provided here is confidential and serves to organize and maintain your records in our office thereby assuring accuracy and, if applicable, proper communication with your insurance provider on your behalf.

Today's Date: *Click here to enter a date.*

Patient Information

Last Name: *Click here to enter text*

First Name: *Click here to enter text*

Preferred Name: *Click here to enter text*

Street Address: *Click here to enter text*

City: *Click here to enter text*

State: *Click here to enter text*

Zip Code: *Click here to enter text*

Home Phone: *Click here to enter text*

Work Phone: *Click here to enter text*

Cell Phone: *Click here to enter text*

Birthdate: *Click here to enter text*

Gender: ☐ **Male** ☐ **Female**

Social Security: *Click here to enter text*

Account Information

(Person financially responsible for account)

Last Name: *Click here to enter text*

First Name: *Click here to enter text*

Street Address: *Click here to enter text*

City: *Click here to enter text*

State: *Click here to enter text*

Zip Code: *Click here to enter text*

Home Phone: *Click here to enter text*

Work Phone: *Click here to enter text*

Cell Phone: *Click here to enter text*

About You

Name: *Click here to enter text*

Occupation: *Click here to enter text*

Employer's Name: *Click here to enter text*

Employer's Address: *Click here to enter text*

Employer's Phone: *Click here to enter text*

Patient Registration

About your spouse *(if applicable)*

Name: *Click here to enter text*

Occupation: *Click here to enter text*

Employer's Name: *Click here to enter text*

Employer's Address: *Click here to enter text*

Employer's Phone: *Click here to enter text*

Dental Insurance *(if applicable)*

Insurance Company: *Click here to enter text*

Group Number: *Click here to enter text*

Employer of insured: *Click here to enter text*

Insured's Name: *Click here to enter text*

Insured's Date of Birth: *Click here to enter text*

Insured's relationship to Patient: *Click here to enter text*

Insured's I.D. Number: *Click here to enter text*

Insured's Social Security: *Click here to enter text*

Secondary Insurance: *(if applicable)*

Insurance Company: *Click here to enter text*

Group Number: *Click here to enter text*

Employer of insured: *Click here to enter text*

Insured's Name: *Click here to enter text*

Insured's Date of Birth: *Click here to enter text*

Insured's relationship to Patient: *Click here to enter text*

Insured's I.D. Number: *Click here to enter text*

Insured's Social Security: *Click here to enter text*

Getting to know you a little

Is a family member a patient of our practice? Yes ☐ No ☐

If yes, what is their name? *Click here to enter text*

How did you learn about our practice? *Click here to enter text*

Who should we contact in the event of emergency? *Click here to enter text*

What is their best phone number? *Click here to enter text*

Who is a closest relative not living with you? *Click here to enter text*

What is their best phone number? *Click here to enter text*

Street Address: *Click here to enter text*

City: *Click here to enter text*

State: *Click here to enter text*

Zip Code: *Click here to enter text*

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-ray radiographs, photographs, study models, and/or other diagnostic aids as deemed appropriate by the doctor to make a thorough diagnosis of the oral health needs of: *Click here to enter text* (enter patient's name)

2. Upon such diagnosis, I authorize the 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 possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying our my treatment, payment, and healthcare operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed.

5. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I understand that payment is due at the 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 1-1/2% late charge, (18%APR), may be added to my account. If required, I also understand a check of my credit history may be made.

Patients Signature: _____ Date: _____

Account Guarantor's Signature: _____Date: _____

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