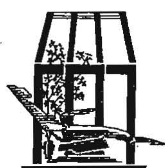

ATRIUM DENTAL CARE

PATIENT REGISTRATION

Patient Number ______________

PATIENT INFORMATION

Patient's name: ______________________ Birthdate: ____/____/____

Street address: ______________________ Phone: (____) __________

City: ______________ State: __________ Zip: __________

Social Security number: ____-____-____ Drivers License number: __________

If a child, parent's name: ______________________

Patient Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

Name of spouse: ______________________ Birthdate: ____/____/____

Social Security number: ____-____-____ Drivers License number: __________

In case of emergency, notify: ______________________ Phone: (____) __________

Person responsible for this account: ______________________

EMPLOYER INFORMATION

Patient employed by: ______________________

Business address: ______________________ Phone: (____) __________

City: ______________ State: __________ Zip: __________

Present position: ______________________ How long held: __________

Spouse employed by: ______________________

Business address: ______________________ Phone: (____) __________

City: ______________ State: __________ Zip: __________

Present position: ______________________ How long held: __________

INSURANCE INFORMATION

Insurance Number ______________

If you have insurance, name of insured: ______________________ Group No: __________

Name of insurance company: ______________ Address: ______________

______________ Insurance phone #: ______________

Is policy connected with a Union? ❑ Yes ❑ No If yes, name of Union: ______________ Local No: __________

If spouse has insurance, name of insured: ______________________ Group No: __________

Name of insurance company: ______________ Address: ______________

______________ Insurance phone #: ______________

Is policy connected with a Union? ❑ Yes ❑ No If yes, name of Union: ______________ Local No: __________

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor.

I am responsible for all costs incurred by the Dental Office for collecting past-due balances on accounts including, but not limited to, service fees, court costs, attorney fees, and agree to pay maximum statutory interest from the date of notice that the account or accounts have been declared delinquent.

Patient Signature (Parent of Child): ______________________ **Date:** __________

Whom may we thank for referring you: ______________________

Comments: ____

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