



PATIENT REGISTRATION

EMERGENCY CONTACT

Name: _____
 Relationship: _____
 Address: _____
 City, State, Zip: _____
 Phone Number: _____
 Physician's Name and Phone Number: _____
 Preferred Pharmacy Name and Phone Number: _____

CLOSEST RELATIVE NOT LIVING WITH YOU

Name: _____
 Relationship: _____
 Address: _____
 City, State, Zip: _____
 Phone Number: _____

RESPONSIBLE PARTY'S PREVIOUS ADDRESS

Address: _____
 City, State, Zip: _____

OTHER INFORMATION

Is another member of your family a patient at our office? Yes No
 If yes, Name: _____ Relationship: _____

How did you decide to join our family of dental patients?

Personal referral--Who may we thank for referring you? _____
 Phone Book Newspaper or Magazine
 Insurance Company Other--Please list: _____

CONSENT FOR TREATMENT/ INSURANCE ASSIGNMENT/ FINANCIAL RESPONSIBILITY/ OFFICE POLICIES

- 1) I hereby authorize the doctor or designated staff to take radiographs (x-rays), study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of this patient's dental needs. I authorize the doctor, following appropriate diagnosis, to perform all recommended treatment mutually agreed upon by the patient, or representative of the patient, and the doctor.
- 2) I agree to the use of anesthetics or other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of these risks.
- 3) I hereby authorize Schultz Family Dentistry to furnish information to insurance carriers concerning my dental needs and treatment, and I hereby assign to Schultz Family Dentistry all payments for services rendered to my dependants or myself. I understand that I am ultimately responsible for full payment of all charges, and Schultz Family Dentistry makes no guarantees of my insurance reimbursement.
- 4) I understand that I am financially responsible for any and all unpaid amounts incurred in treatment. I understand that accounts that are 30 days past due are subject to a minimum service charge of \$5.00 or 2.5% of the outstanding balance per month, whichever is greater.
- 5) I understand that if my account remains unpaid and is forwarded to a collection agency, I will be responsible for any reasonable collection costs, including reasonable attorney fees. I understand that, if required, a check of my credit history may be made.
- 6) I understand that, if required/ necessary, a check of my credit history may be made.
- 7) I understand that in the event that my check is returned to Schultz Family Dentistry from the bank, I will be charged \$30.00. I understand that I will be required to pay the amount of the original check plus the service fee within five business days by cashier's check, money order, cash, or credit card. If I fail to do this, my account may be turned over to a collection agency.
- 8) I understand that a minimum of 24 hours notice is required for cancellation of appointments. A broken appointment fee may be charged to my account and is payable by me if a 24 hour notice is not given.

Patient Signature: _____ Date: _____ Witness: _____

Responsible Party's Signature: _____ Date: _____ Witness: _____