PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

①

PATIENT'S NAME			
SPOUSE			
MAILING ADDRESS			
CITY		STATE	ZIP
PHYSICAL ADDRESS			
CITY		STATE	ZIP
HOME PHONE #		CELL #	
EMAIL ADDRESS			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

② ACCOUNT INFORMATION

PERSON FINANCIALLY REPONSIBLE FOR ACCOUNT			
NAME RELATIONSHIP TO PATIENT			
MAILING ADDRESS			
CITY		STATE	ZIP
PHYSICAL ADDRESS			
CITY		STATE	ZIP
SOCIAL SECURITY NO		DRIVERS LICENSE NO	
HM PHONE NO		WK PHONE NO	

③

PATIENT OR PARENT EMPLOYER			
NAME			
OCCUPATION			
EMPLOYER			
BUSINESS ADDRESS		CITY	
BUSINESS PHONE NO			EXT

④

YOUR SPOUSE			
NAME			
OCCUPATION			
EMPLOYER			
BUSINESS ADDRESS		CITY	
BUSINESS PHONE NO			EXT

⑤ DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO	ID#
EPMLOYEE	EFFECTIVE DATE
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER NAME	
EMPLOYEE SOCIAL SECURITY NO	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO	ID#
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER NAME	
EMPLOYEE SOCIAL SECURITY NO	

⑥ GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT IN OUR OFFICE?		
NAME	RELATIONSHIP	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
	RELATIONSHIP	
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
	RELATIONSHIP	
PHONE NUMBER		
PHYSICAL ADDRESS		
CITY	STATE	ZIP

(Please complete other side)

William Holmes DDS **Ryan Coombs DDS**

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor's 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 and to employ such assistance as required to provid 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 to any possible complications.

4. I understand that payment is due at the time of service, as a courtesy, we will submit claims to your insurance company. Predeterminations are not a guarantee. If you find it necessary to cancel or not show up for an appointment without 24 hour notice then there will be a charge applied.

5. FINANCIAL ARRANGEMENT: Should payment arrangements become necessary, I will comply with arrangements made and fully understand that if my account balance (regardless of insurance status) goes past 90 days, a monthly service charge of 1.83% (22% APR) will be assessed on that balance and added to my account.

Patient Signature_____Date_____

Parent or Responsible Party Signature_____

Relationship to Patient_____

HIPPA PRIVACY POLICY

Our office is fully committed to compliance with HIPPA guideline by:

1. Providing appropriate SECURITY for our records.
2. Protecting the PRIVACY of our patients medical information.
3. Providing our patients with proper ACCESS to their medical records, once a signed release is obtained.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPPA STANDARDS.
5. Not providing patient data to marketers or pharmaceutical companies for purpose of research.

I acknowledge that I have read and understand the privacy policy of William Holmes and Ryan Coombs.

Patient Signature_____Date_____

Parent or Responsible Party Signature_____

Relationship to Patient_____