DeJesus Dental Group
COSMETIC, FAMILY & IMPLANT DENTISTRY

Age_____ Date_____

Patients Name_____ Date of Birth_____ □Male □ Female
Last *First* *Initial*

If Child: Parent's Name_____

How do you wish to be addressed?_____

□ Single □ Married □ Separated □ Divorced □ Widowed □ Minor

Residence – Street_____

City_____State_____Zip_____

Business Address_____

Telephone: Res._____ Bus._____

Fax_____Cell Phone #_____

Email_____

Patient/Parent Employed By_____

Present Position_____

How Long Held_____

Spouse/Parent Name_____

Spouse Employed By_____

Present Position_____

How Long Held_____

Who is Responsible for this account_____

Driver's License No._____

Method of Payment: □ Insurance □ Cash □ Credit Card

Purpose of Call_____

Other Family Members in this Practice_____

_____

Whom may we thank for this referral_____

Patient/Parent Social Security No._____

Spouse/Parent Social Security No._____

Someone to notify in an emergency not living with you_____

_____(_____)_____-_____

Dental Insurance
1st COVERAGE

Employee Name_____Date of Birth_____

Relationship to Patient_____

Employer Name_____

Name of Insurance Co._____

Address_____

Telephone_____

Program or Policy #_____

Social Security No._____

Union Local or Group_____

Dental Insurance
2nd COVERAGE

Employee Name_____Date of Birth_____

Relationship to Patient_____

Employer Name_____

Name of Insurance Co._____

Address_____

Telephone_____

Program or Policy #_____

Social Security No._____

Union Local or Group_____

CONSENT:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care. My consent to disclosure of records shall be effective until I revoke in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreement to the contrary and agree to be responsible for payment of services not paid, by my dental care payer.

I attest to the accuracy of the information on this page.
PATIENT'S OR GUARDIAN'S SIGNATURE

X_____

DATE_____

REGISTRATION