PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1			
DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.	CELL#		
E-MAIL:			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
E-MAIL:			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE 2		
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION 4		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU 3		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

TREATMENT AND FINANCIAL CONSENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize the doctor to perform recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that I can ask for complete recital of risks and benefits of any treatment rendered.
3. I agree to the use of anesthetics, sedatives and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf, my spouse or my dependents. I understand that payment is due at the time of service unless other arrangements have been made in writing and are signed by this office and the parent/ responsible party. If we do not receive payment at the time of service and there is no arrangement made in writing, I understand that interest will begin to accrue on any remaining balance on my account 30 days after the date of service at the rate of 1.5% per month (18% per annum). I understand that interest will continue to accrue at this rate until the remaining balance is paid in full. I also understand that if any account is placed with an attorney or collection agency because of any unpaid balance remaining on my account, I hereby agree and promise to pay a one-time collection fee of $100.00 or 30% of any unpaid balance on my account at the time of placement with the attorney or collection agency, whichever is greater.
5. For those patients who are covered by insurance, we will accept assignment of benefits as a courtesy. Most dental insurance plans do not cover 100% of the cost of your dental treatment. Because of the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and a portion of your charges the day the services are rendered. We will ESTIMATE as closely as possible your coverage, but until we actually receive the payment from the insurance company, it is just an ESTIMATE.
6. A $30.00 service fee will be charged for any returned checks.
7. We take much pride in the fact that a majority of the time our patients do not have to "wait" in the waiting room. We believe your time is as valuable as ours. **If an appointment is canceled without 48 hour prior notice or a patient does not show for an appointment, a $75.00 fee will be charged.** This payment will be sent to the Food Bank of Monmouth and Ocean Counties. With respect to subsequent cancellations or broken appointments, the patient will be seen at the doctor's convenience.

We appreciate your cooperation with regards to these matters. Our office runs more smoothly with your help and therefore enables us to give our patients optimal treatment.
The undersigned has read and understands the above consent for treatment and policies and agrees to all the terms set forth above.

Signature_____ **Date**_____ **Witness**_____
Parent/Responsible Party's Signature_____
Relationship to patient_____

PHOTO RELEASE

Your signature below indicates your consent for Drs. Graber and Peters to use or reproduce photographs or computer illustrations of your teeth for educational or marketing purposes. You waive claim that the use of images defames you or constitutes an infringement of your rights to privacy. It is not mandatory that you sign this paragraph and you agree that if you choose to sign it is done freely and voluntarily.
Signature_____ **Date**_____