university family dental
Comprehensive, experienced care for exceptional outcomes.

Registration Information:

Patient Name: _____ Preferred Name: _____ Date: _____
(print)

Mailing Address: _____ City, State, & Zip Code: _____

E-mail: _____ Cell Phone #: _____ Alt Phone #: _____

Birthdate: _____ Social Security #: _____ Male ___ Female ___

Marital Status: Married Single Child Other

Preferred contact method: Phone E-mail Referred By: _____

Employer: _____ Job Title: _____

Who is responsible for this account? _____ Relation to Patient: _____
(print name)

Emergency Contact: _____ Relation to Patient: _____ Phone #: _____
(print name)

Consent for Treatment:

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to mine or my child/dependent's medical and/or dental health. I authorize the dental staff to perform necessary dental services for myself or my child/dependent. This includes, but is not limited to x-rays and the administering of anesthetics advised by the Doctor.

Financial Agreement:

I certify that I understand that I am responsible for all charges, whether or not it is paid by my insurance, if applicable. I authorize the use of my signature on all insurance claims/submissions billed on my behalf for services rendered. If applicable, the provided health care information may be disclosed to my insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance eligibility for service and payment.

This consent will remain effective throughout treatment time at University Family Dental, LLC unless identified and a new agreement is signed. I am responsible for notifying the staff of any changes to my insurance, health conditions, or contact information.

Printed Name: _____ **Signature:** _____ **Date:** _____