university family dental

Comprehensive, experienced care for exceptional outcomes.

**Registration Information:** **Date: _____**

Patient Name: _____Preferred Name: _____

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: Text E-mail Call Referred By: _____

Employer:_____ Job Title: _____

Who is responsible for this account? _____ Relation to Patient: _____

Emergency Contact: _____

Relation to Patient: _____ Phone #: _____

**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 or Hygienist.

**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.

**Warranty of Treatment:**

We want to make your mouth comfortable and are pleased to repair or replace our dental work/appliances, if viewed necessary with due cause; within six months for night guards, one year of placement of fillings, and three years within placement for crowns, bridges, and dentures. **All recommended hygiene recalls must be up to date for the warranty to be considered.**

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