

Southern Boulevard Dental Corp, PA
PATIENT REGISTRATION

First Name: _____ Last Name: _____ Nickname: _____
Patient is: Policy Holder Responsible Party Referred by: _____

Patient Information

Home Address: _____ City, State, Zip: _____
Home Phone: _____ Cellular: _____ Pager: _____
Employer: _____ Work Phone: _____ Ext: _____
Employer Address: _____ City, State, Zip: _____
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: _____ Age: _____ Soc. Sec.: _____ Driver's Lic.: _____
E-mail: _____ I would like to receive correspondences via e-mail.
Other Family Members: _____

Responsible Party (if someone other than the patient) Relationship to Patient _____

First Name: _____ Last Name: _____
Home Address: _____ City, State, Zip: _____
Home Phone: _____ Cellular: _____ Pager: _____
Employer: _____ Work Phone: _____ Ext: _____
Employer Address: _____ City, State, Zip: _____
Birth Date: _____ Soc. Sec.: _____ Driver's Lic.: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec.: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other
Insured Soc. Sec.: _____ Insured Birth Date: _____
Employer: _____ Ins. Company: _____
Address: _____ Address: _____
Address 2: _____ Address 2: _____
City, State, Zip: _____ City, State, Zip: _____

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I authorize Doctor to release health information obtained from me to third party payors and/or other health providers. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (I) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. A \$50 charge will be made for broken appointments without 48 hours notice.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE