TUSCULUM
Dental Care

PATIENT REGISTRATION

Please take a moment to enter your information to help us provide excellent care.

Patient Information

Date:	Patient Name:		
Address:	City:	State:	Zip:
Home #:	Cell #:	Work #:	
Email:		Social Security #:	
Birth date:	Age:	Gender: M / F	
Marital Status: Married	Single	Widowed	Divorced
If minor: School:		Grade:	
Occupation:		Employer:	
Business Address:			
Interests/Hobbies:			
Preferred Appointment Day:		Preferred time: Morning / Afternoon / Anytime	
Whom may we thank for referring you to our practice?			

Spouse or Responsible Party

Name:		Relationship to Patient:	
Address: *(if different from above)*			
City:	State:	Zip:	
Home #:	Cell #:	Work #:	
Employer:			
Business Address:			

Dental Insurance

PRIMARY Insurance Company Name:		Phone #:	
Employee:	Employer:		
Date employed:	Date of Birth:		
Group No:	Employee Social Security No.:		
SECONDARY Insurance Company Name:		Phone #:	

Emergency Contact

Name :		Relationship:	
Home #:	Cell #:	Work #:	
Address:	City:	State:	Zip:
Name of closest relative not living with you:			
Home #:	Cell #:	Work #	
Address:	City:	State:	Zip:

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as 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.

Signature of patient, parent or guardian: _____ Date: _____

Witness: _____