Print Form

Patient Registration Information **CONFIDENTIAL**

Date_____

Name_____ _____ _____ _____

First MI Last Nickname

Home Address _____ City _____ State WY_____ Zip _____

Birthdate _____ SS# _____ Driver's License#_____ E-Mail_____

Home Phone _____ Work Phone _____ Cell Phone _____

Do you prefer to receive calls at ☐ Home ☐ Work ☐ Cell

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your employer _____ Occupation _____

Business Address _____City _____State WY_____ Zip _____

Spouse or parent/Guardian's name _____ Employer _____ Work Phone _____

If you are a student, name of school/ college _____ City _____ State WY_____

Person to contact in case of an emergency _____ Phone _____

Responsible Party (please fill out if different from above patient)

Name of person responsible for this account _____ Relationship _____

Home Address _____ City _____ State WY_____ Zip _____

Birthdate _____ SS# _____ Driver's License # _____

Home Phone _____ Work Phone _____ Cell Phone _____

E- Mail _____ Financial Institution _____ Employer _____

Is this person currently a patient in our office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Birthdate _____ SS# _____

Relationship to patient _____ Employer _____ Phone _____

Insurance Company _____ Phone # _____ Employer _____

Claims will be filed as a courtesy: Any payments will be sent to the insured. I am responsible for payment for services.

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize Dr. McHenry Lee to release any information, including the diagnosis and the records of any treatment or examination, rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I have read and understand all of the above:

X_____ **_____**

Signature of Patient or parent/ guardian if minor **Date**

I hereby authorize taking of photographs prior to, during, and after treatment. This is for educational purposes, insurance purposes, or for records that are being sent to a dental lab is necessary.

I, _____ , consent to the taking of photographs.