

**Patient Registration Information**

**CONFIDENTIAL**

Date \_\_\_\_\_  
Name \_\_\_\_\_  
                    First                                    MI                                    Last                                    Nickname  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ 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 \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or parent/Guardian's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
If you are a student, name of school/ college \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
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 \_\_\_\_\_ 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.