PEACHTREE DUNWOODY DENTAL GROUP

Patient Registration

Patient Information Date:_____

Name:_____ What would you like to be called?_____

Address: _____City_____ State_____ Zip_____

Birthdate: _____ Telephone: (Home) _____ (Office) _____Marital Status: _____
(Month/Day/Year)

Place of Employment: _____ Occupation: _____

Business Address: _____City_____ State_____ Zip _____

Dental Insurance Co.:_____ Group No.:_____

Social Security #: _____ Date Employed: _____

Are any relatives patients in our office? Yes No Name: _____

Whom may we thank for referring you to our office? _____

Family Information

	Husband (or Father)	Wife (or Mother)
Name:		
	Last First	Last First
Address:		
	Street City State/Zip	Street City State/Zip
Telephone #:		
	Home # Work #	Home # Work #
Birthdate/SSN:		
	Mo Day Year SSN	Mo Day Year SSN
Employer:		
	Employer	Employer
Dental Ins. Co.:		
	Dental Insurance Group #	Dental Insurance Group #

Person responsible for account _____

Person to contact in case of emergency _____

Payment options - Please check one of the following:

_____ Payment in full at each appointment

_____ Individual financial arrangements (set up prior to service rendered)

Finance charge: If I do not pay the entire New Balance within 90 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.0% per month which is an annual percentage rate of 12% applied to the last month's balance. In the case of default of payment I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account.

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Authorization/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 the 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.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made.

Patient_____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____