DAVIDSON
FAMILY DENTAL

Health History and Registration

Patient Information

Patient Name: ________________ Age: _______ Birthday: ________________ Sex: M F

For minor patient, name of Parent or Guardian: ________________

Who may we thank for referring you to our office? ________________

Person Responsible for the Account

Name: ________________ Birthday: ________________ Marital Status: ________________

Home Address: ________________ City: ________________ Zip: ________________

Social Security Number: ________________ Primary Phone: ________________ Secondary Phone: ________________

Email Address: ________________

Employed By: ________________ Occupation: ________________

Relation to the Patient: ________________ Spouse's Name: ________________

Dental Insurance: **Yes /No** Name of Company: ________________

Address of Dental Insurance Company: ________________

Group Number: ________________

Dental History

Name of previous dentist: ________________

How long since your last dental cleaning and/or exam? ________________

How nervous are you about having dental treatment? (Please circle) 1 2 3 4 5

I hereby authorize Davidson Family Dental to administer medications and perfore diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible to pay for services rendered, which may include reasonable legal fees and costs of collection in the event of default. My dental insurance does not relieve me of this responsibility as it is a contract between me and the insurance carrier, and not between the doctor and the insurance carrier. Fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I assign all the insurance benefits to the doctor, understanding any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have already paid the dental fees incurred. I further understand that if any payment becomes 30 days past due delinquency charges of the lesser of the annual rate of 12% or the maximum allowable rate will be due on the full balance from the date the payment was due.

The information I have given on both sides of this page is correct to the best of my knowledge.

Signature of the Responsible Party: ________________ **Date:** ________________

Please Circle: Patient Parent Guardian