DiChristofano & DiChristofano
QUALITY DENTISTRY, COMPASSIONATE CARE

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Registration

1. Patient name _____Date of birth _____ M__ F __
   Last First P
2. With what name does the patient wish to be addressed? _____
3. If child: Parent's name _____
4. Home address _____
   City _____ State _____ Zip _____
   Phone: Cell _____ Home _____ Work _____
   Email address _____ Fax _____
5. Patient/Parent Social Security No. _____
6. Patient/Parent employed by _____
7. Employer address _____
   City _____ State_____ Zip _____
8. Present position _____
9. Spouse name _____
10. Spouse Social Security No._____
11. Spouse employed by _____
12. Employer address _____
    City _____ State _____ Zip _____
13. Present position _____
14. Who is responsible for this account _____
    Relationship to patient _____
15. Billing address of responsible person:
    City _____ State _____ Zip _____
16. Person to notify in case of an emergency _____
    Relationship to patient _____
    Phone: Cell _____ Home _____ Work _____
17. Whom may we thank for this referral? _____

Dental Insurance 1st Coverage

18. Employee name _____Date of birth _____
19. Employer name _____

20. Name of Insurance Company _____
21. Address:
City _____ State _____ Zip _____
22.Insurance Phone No._____
23. Program or Policy No. _____
24. Social Security No. _____
25. Union Local or Group No. _____

Dental Insurance 2nd Coverage

26. Employee name _____ Date of birth _____
27. Employer name _____
28. Name of Insurance Company _____
29. Address:
City _____ State _____ Zip _____
30. Insurance Phone No. _____
31. Program or Policy No. _____
32. Social Security No. _____
33. Union Local or Group No. _____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care and that treatment which has been explained to me in my treatment plan.

I consent to the dentist's use and disclosure of my records (or my child's records) and dental photography to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

My consent to the disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my benefits may pay less than the actual bill of services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I certify that the above information is complete and accurate.

Patient's or Guardian Signature
_____ Date _____