REGISTRATION

form-of95

START HERE

DATE TODAY

YOUR NAME	PHONE

LIKE TO BE CALLED

HOME ADDRESS

SOC SEC NO

EMPLOYER

ADDRESS

WORK PHONE

DATE OF BIRTH	AGE	MALE	FEMALE
MARRIED	SINGLE	DIV	WIDOWED

PATIENT'S PHYSICIAN

NAME

CITY PHONE

REFERRED BY

NAME

RELATIONSHIP TO PATIENT

CONSENT FOR TREATMENT AND PAYMENT FOR SERVICES

I AUTHORIZE NECESSARY X-RAYS , LOCAL ANESTHESIA, MEDICATION AND TREATMENT DEEMED NECESSARY AND AGREE TO BE RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT THE OFFICE WILL ASSIST WITH INSURANCE FORMS BUT THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT IN FULL FOR SERVICES RENDERED.

SIGNATURE _____

YOUR SPOUSE

NAME

EMPLOYER

BUS ADDRESS

WORK PHONE

DENTAL INSURANCE PRIMARY CARRIER

EMPLOYEE NAME

SOC SEC NO BIRTHDATE

INSURANCE COMPANY

INSURANCE CO. ADDRESS

GROUP NO

PHONE

SECONDARY CARRIER

EMPLOYEE

SOC SEC NO BIRTHDATE

INSURANCE CO

ADDRESS

GROUP NO

INSUR CO PHONE

Thank you and Welcome to the Practice

Stanley C. Kimball, D.D.S.