Patient Registration

Patient Information

Name _____ *Nickname* _____

Address _____

City _____ *State* _____ *Zip* _____

Home Phone _____ *Work Phone* _____ *Cell Phone* _____

Sex _____ *Marital Status* _____ *Spouse's Name* _____

Date of Birth _____ *Soc. Sec. Number* _____

Email _____

Employer _____ *Occupation* _____

Emergency Contact _____ *Phone* _____ *Relationship* _____

Insurance and Financial Information

Dental Insurance Company _____

Insurance Company Address _____

Subscriber's Name _____ *Employer* _____

Identification Number _____ *Group Number* _____

Relationship to Patient _____ *Method of Payment* _____

Affirmation, Assignment & Release

I affirm that all information I have given today on this registration and the medical/dental form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I consent to the making of necessary x-rays, study models, photographs, and videotapes before, during, and after treatment, and to their use by Dr. Raptou for exam, study, diagnosis, treatment, documentation, for patient education and demonstration, for dental educational lectures, and in scientific papers without patient compensation.

If I have dental insurance, I hereby authorize my insurance benefits to be paid directly to Dr. Raptou and authorize his office to release any information pertaining to my dental insurance. Regardless, I understand that I am financially responsible for all charges whether or not paid by my insurance. I certify that I have read or had read to me the contents of this affirmation, assignment, and release, and realize the risks and limitations involved.

Signature _____ *Date* _____