EASTSIDE DENTAL CLINIC

PATIENT REGISTRATION & FINANCIAL FORM

FULL NAME OF **PATIENT**_____HOME PHONE_____

HOME ADDRESS _____ HOW LONG? _____

CITY_____STATE_____ZIP_____ ☐ OWN ☐ RENT ☐ OTHER

AGE_____BIRTHDATE_____SOCIAL SECURITY # OF **PATIENT**_____

DRIVERS LICENSE _____MARITAL STATUS_____REFERRED BY_____

*E-MAIL ADDRESS_____*CELL PHONE #_____

PREFERRED METHOD OF CONTACT: (mark all that apply) E-MAIL_____PHONE_____ TEXT_____

☐ **I AUTHORIZE EASTSIDE DENTAL INFORMATION BE SENT TO ME UTILIZING MY E-MAIL ADDRESS AND/OR TEXT REMINDER.**

EMPLOYER_____HOW LONG?_____POSITION_____

ADDRESS_____PHONE_____

SPOUSE'S NAME_____BIRTHDATE_____SOCIAL SECURITY #_____

SPOUSE'S EMPLOYER _____ PHONE _____

WHAT PHARMACY DO YOU USE? _____ PHONE _____

EMERGENCY CONTACT_____PHONE_____
(SOMEONE AT DIFFERENT ADDRESS)

NAME OF PARENT OR GUARDIAN_____

RELATIONSHIP TO PATIENT_____SOCIAL SECURITY #_____

BIRTHDATE_____HOME PHONE_____CELL PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____HOW LONG?_____POSITION_____

ADDRESS_____PHONE_____

PERSON RESPONSIBLE FOR ACCOUNT *AT APPOINTMENT DATE*_____

RELATIONSHIP TO PATIENT_____SOCIAL SECURITY #_____

BIRTHDATE_____HOME PHONE_____CELL PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER_____HOW LONG?_____POSITION_____

ADDRESS_____PHONE_____

DRIVERS LICENSE _____MARITAL STATUS_____SPOUSE'S NAME_____

I understand that the information provided on this form is essential to determine my dental needs and the provision of my dental care. I agree to promptly report any changes in my health, insurance coverage or other information, such as home or billing address and phone number, which are essential to the maintenance of my account. Patient balances are due in full at the time of service by patient or adult present at the appointment. (We accept cash, check, Visa, MasterCard, Discover & debit card). Accounts with an outstanding balance are subject to a rebilling fee of one and one-half percent per month. Accounts sent to collection are subject to a handling fee. Cancellations without 48 hours notice may incur a $100. fee. Dental services are a legal contract between patient and Doctor. I have read, completed and understand the contents of this form.

SIGNATURE_____**DATE**_____
(PATIENT OF LEGAL AGE *OR* PARENT/GUARDIAN IF A MINOR)

_____REC'VD _____INPUT