Murray Dental Care

CHILD PATIENT REGISTRATION FORM

PATIENT INFORMATION					
DATE	PREFERRED NAME	SOCIAL SECURITY #	M	F	DATE OF BIRTH
LEGAL NAME: LAST FIRST MIDDLE			PHONE [HOME]		PHONE [CELL]
ADDRESS CITY STATE ZIP			EMAIL ADDRESS		
IF FULL TIME STUDENT, NAME OF SCHOOL		FATHER'S NAME		MOTHER'S NAME	
OTHER FAMILY MEMBERS SEEN IN THIS PRACTICE (INCLUDE LAST NAME IF DIFFERENT THAN PATIENT)					

RESPONSIBLE PARTY / INSURANCE INFORMATION			
PRIMARY INSURED: LAST FIRST MIDDLE	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
ADDRESS CITY STATE ZIP	PHONE [HOME]	SOCIAL SECURITY #	
EMPLOYER	EMPLOYER ADDRESS	PHONE [WORK]	
INSURANCE COMPANY NAME	GROUP #	IS PATIENT COVERED UNDER THIS INSURANCE? YES / NO	
INSURANCE COMPANY ADDRESS		EFFECTIVE DATE	

COMPLETE IF COVERED BY MORE THAN ONE INSURANCE			
SECONDARY INSURED: LAST FIRST MIDDLE	DATE OF BIRTH	RELATIONSHIP TO PATIENT	
ADDRESS CITY STATE ZIP	PHONE [HOME]	SOCIAL SECURITY #	
EMPLOYER	EMPLOYER ADDRESS	PHONE [WORK]	
INSURANCE COMPANY NAME	GROUP #	IS PATIENT COVERED UNDER THIS INSURANCE? YES / NO	
INSURANCE COMPANY ADDRESS		EFFECTIVE DATE	

CONSENT TO TREAT - I consent to treatment as necessary or desirable to the care of the above named patient. **INSURANCE RELEASE -** I authorize the release of any dental information necessary to process insurance claims. **ASSIGNMENT OF BENEFITS** - I authorize payment to be made to Murray Dental Care for dental services rendered. **FINANCIAL AGREEMENT -** The undersigned agrees whether he (she) signs this form as patient or agent of the patient that in consideration of services to be rendered by Murray Dental Care, he (she) obligates himself (herself) to pay the account in accordance with the regular fees and terms, which are subject to change without notice. Patients who carry dental insurance should know all professional services furnished are charged directly to the patient. He (she) is personally responsible for payment regardless of insurance coverage. We will prepare any necessary forms to assist in making collection from the insurance company. In the event this account is referred to collection, the patient or the patient's agent shall pay reasonable attorney's fees and collection expenses. **FINANCE CHARGE** - A finance charge of 1.5% per month is added to accounts over 60 days old. **FAILED APPOINTMENTS -** We request that you notify this office at least 24 hours in advance of any appointment change or cancellation. Failure to do so may result in a missed appointment fee.

SIGNATURE _____ RELATIONSHIP _____ DATE _____ .