PDA

PETOSKEY DENTAL ASSOCIATES ~ 1301 US Hwy 131 Petoskey, MI 49770 ~ (231) 347-2100 ~ www.petoskeydental.com

Registration Form

Patient Information:			**Dental Insurance Information:**
Last Name:	First Name:	Middle Int:	Insurance Company:
Prefers to be called:			Employer Name:
Address:			I.D. Number/S.S. #:
City:	State/Zip:		Group Number:
Home Phone:	Cell Phone:		Subscriber's Name:
Email:			Subscriber's Date of Birth:
Birthday:	Male or Female		***Secondary Insurance Information:***
Social Security Number:			Insurance Company:
Getting to Know You:			Employer Name:
Occupation:			I.D. Number/S.S. #:
Employer:			Group Number:
Who were you referred by:			Subscriber's Name:
Person to contact in case of an emergency: Name:	Phone Number:		Subscriber's Date of Birth:

If the patient is a minor, or the last name or address are not the same, please complete:	
Last Name:	First Name:
Prefers to be called:	
Address:	
City:	State/Zip:
Home Phone:	Cell Phone:
Email:	
Birthday:	Male or Female
Social Security Number:	

Patient Consent for Treatment

1) I hereby authorize the doctor or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2) Upon diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon to employ such assistance as required to provide proper care.
3) I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4) I give consent for the disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations. I understand that only the minimal amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5) ☐ I authorize Petoskey Dental Associates to share my dental information with immediate family
6) Preferred methods of contact: (*please check boxes*) ☐ *Call* ☐ *Text* ☐ *Email*

Patient/Guardian Signature: ______________________________ Date________________