LAURA A. EARNEST, D.D.S.

A PROFESSIONAL CORPORATION

FAMILY AND COSMETIC DENTISTRY

PATIENT REGISTRATION

Welcome to our office. Thank you for providing the following confidential information.

PATIENT INFORMATION

Name _____ Home Phone _____ Office _____

Mailing Address _____ Mobile Phone _____ Pager _____

City and State _____ Place of Employment _____

Zip Code _____ Social Security No. _____

Date of Birth _____ Whom may we thank for referring you to our office? _____

Incase of emergency notify _____ Relationship _____

Home Telephone No. _____ Office Telephone No. _____

PAYMENT INFORMATION

Name of Responsible Party
(if other than patient) _____

Address _____

City, State, Zip _____

Home Telephone No. _____

Place of Employment _____

Office Telephone No. _____

METHOD OF PAYMENT

Cash/Check ☐

Mastercard/Visa ☐

Insurance ☐

DENTAL INSURANCE (Primary Carrier)

Insured's Name _____

Insured's Social Security No. _____

Insured's Place of Employment _____

Insurance Co. _____

Insured's Date of Birth _____

DENTAL INSURANCE (Secondary Carrier)

Insured's Name _____

Insured's Social Security No. _____

Insured's Place of Employment _____

Insurance Co. _____

Insured's Date of Birth _____

CONSENT

The undersigned here by authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Signature _____ Date _____ ☐ Patient ☐ Parent ☐ Guardian