Lindenhurst Dental
Health Group
John K. Favale D.D.S.

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Patient Registration Form

PLEASE PRINT

Patient's Name_____ **Today's Date:**_____
Last First MI

Name you prefer to be called by:_____

DOB: _____ / _____ / _____ **Age:**_____ **Soc. Security Number:** _____ / _____ / _____
Male / Female *(Please circle one)* Marital Status: Single Married Divorced *(Please circle one)*
Address:_____
City:_____ **State:**_____ **Zip:**_____ Who referred you to our office:_____
Home telephone: _____ Referring Doctor's Name:_____
Work telephone: _____**Cell number:**_____
EMAIL:_____
Who will pay on this account?_____

Responsible Party: (If different from patient or if patient is a minor)

Name:_____ Relationship to Patient_____
Last First Mi
Address: _____ Social Security No:_____
Street City State Zip
Home Phone:_____ Wk:_____ Employer:_____ Phone:_____

Emergency Contact:

Contact Person not living with you: Name:_____ Phone: _____

Insurance Information:

Primary DENTAL Insurance Coverage Information:

Name of Insurance Co._____
Co. Address:_____
Co. Phone:_____
Plan/I.D. #_____
Policy Holder's Name:_____
Policy Holder's Date of Birth:_____
Policy Holder's Soc Sec #_____
Employer:_____

Secondary DENTAL Insurance Coverage info:

Name of Insurance Co._____
Co. Address:_____
Co. Phone:_____
Plan/I.D. #_____
Policy Holder's Name:_____
Policy Holder's Date of Birth:_____
Policy Holder's Soc Sec #_____
Employer:_____

Consent For Treatment

1 I hereby authorize doctor or designated staff to take x-rays,study models,photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of **(name of patient)**_____**'**s dental needs.

2 Upon such diagnosis, I authorize doctor to perform a recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3 I agree to the use of anesthetics, sedatives and other medication 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 agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service**, unlessother arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% apr) may be added to my account. If required I also understand a check of my credit history may be made.

Patient's Signature _____Date_____ Witness_____

Parent/Responsible Party's Signature_____ Realtionship to patient_____