PATIENT REGISTRATION

Please take a moment to complete the following information to help us insure the quality of your care.

Date ____

Last Name _______________________________________ First Name ____________________________ MI ___________

Address ____ City ________________________ State _________ Zip ________

Home Phone ______________________________________ Cell ____

Work Phone ______________________________________ E-Mail ____

D.O.B. ____ Social Security No. ____________________________

Preferred Contact Method Home ☐ Work ☐ Cell ☐ E-mail ☐

Emergency Contact Information Name ____

Address ____

Phone # _________________________________ Relationship _____________________

Primary Insurance Information

Subscriber Name ________________________________

Insurance Co ___________________________________

Group # ___________________ ID# ________________

Employer ______________________________________

Date of Birth _______________ Relationship __________

Insured's Social Security # _________________________

Secondary Insurance Information

Subscriber Name ________________________________

Insurance Co ___________________________________

Group # ___________________ ID# ________________

Employer ______________________________________

Date of Birth _______________ Relationship __________

Insured's Social Security # _________________________

Account Information

Person Financially Responsible for Account

First Name _____________________________________ Last Name ____

Relationship to Patient ____________________________

Social Security No. ________________________________

Address _______________________________________ City ________________________ State _____ Zip __________

Phone Number ___________________________________

Getting to Know You

Your Occupation ________________________________ Employer's Name ____________________________________

You Were Referred to Us By _______________________ Person to Contact for Emergency _______________________

Authorization for Signature on File Release of Information/Financial Responsibility/Authorization for Payment

I, ________________________________ and or________________________________
Name of Patient (Parent/Guardian) Name of Insured
hereby authorize the office of Guy Mangia, DDS, to affix my name to any and all insurance claims or documents as related to any and all health benefits due me and my dependants through my dental insurance company. I hereby authorize payment of dental benefits otherwise payable to me to the office of Guy Mangia, DDS . I have reviewed the treatment and fees; I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan. I authorize release of any information relating to the claim. This "Authorization" will be valid from this date or as long as the patient is active in the practice. A photo copy of this document may act as the original.

________________________________ ________________________________
Signature of Insured Witnessed By

________________________________ ________________________________
Signature of Patient (Parent or Guardian) Today's Date

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 all 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 give consent to the doctor's or designated staff's use and 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 minimum 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 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 unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that late charges and finance charges at 18% APR may be added to my account on balances older than 60 days.

Patient's Signature____

Date________________________ Witness________________________

Parent/Responsible Party's Signature________________________________