

# John T. Green DDS Inc.

# Patient Registration

Please complete the following Confidential Questionnaire:

Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone Number ( ) \_\_\_\_\_  
Cell Phone Number ( ) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Marital Status  M  S  D  W  Under Age 18  
Email Address \_\_\_\_\_  
Patient's Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Business Phone ( ) \_\_\_\_\_  
Ok To Call Work  Yes  No  
Spouse's/Guardian's Name \_\_\_\_\_  
Spouse's/Guardian's Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone Number ( ) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Spouse's/Guardian's Employer \_\_\_\_\_  
Spouse's/Guardian's Occupation \_\_\_\_\_  
Spouse's/Guardian's Business Phone ( ) \_\_\_\_\_  
Ok To Call Work  Yes  No

### Getting to know you

Is another member of your family a patient at our office?

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Person to Contact for Emergency \_\_\_\_\_  
Phone Number ( ) \_\_\_\_\_  
Referred to us by \_\_\_\_\_  
Closest Relative not living with you \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

### Account Information

Person Financially Responsible for Account \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

### Consent for Treatment / Assignment / Release

*I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I agree to be responsible for payment on all services rendered on my or my dependent's behalf. I understand that payment is due at the time of service unless other financial arrangements have been made. In the event payments are not received within sixty days of service, I understand that 1 1/2% interest charge (18% APR) will be applied to my account regardless of insurance payment status.*

*I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I hereby authorize doctor or designated staff to take x-rays, study models, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. Upon 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. 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. I certify that I have read or had read to me the contents of this form and fully understand the content.*

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

### Dental Insurance

Insurance Coverage  Yes  No  
Unless All Insurance Information Is Complete We Can Not Process

### Primary Insurance

Insurance Company \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insurance Phone Number ( ) \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Patient's Relationship To Subscriber  
 Self  Spouse  Dependent  
Subscriber's Date of Birth \_\_\_\_\_  
Subscriber's SSN \_\_\_\_\_  
Group/Program Number \_\_\_\_\_  
Member ID Number \_\_\_\_\_

### Secondary Insurance

Insurance Company \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insurance Phone Number ( ) \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_  
Patient's Relationship To Subscriber  
 Self  Spouse  Dependent  
Subscriber's Date of Birth \_\_\_\_\_  
Subscriber's SSN \_\_\_\_\_  
Group/Program Number \_\_\_\_\_  
Member ID Number \_\_\_\_\_