Patient Registration

Mike Choi, D.D.S., Prosthodontist

Welcome to our office! Please complete the following confidential information. We sincerely appreciate you choosing us as your dental office. We look forward to helping you become a part of our family of patients.

Date ____

Name ____________ / ____________ / ________ PREFER TO BE CALLED ____________
LAST FIRST M.I.

Address ____________________ / ____________ / ________ / ________
STREET CITY STATE ZIP

Telephone Numbers ( ) ____________ /( ) ____________ /( ) ____________ /
HOME WORK CELL

EMAIL ____

Birthdate ____________ Age ____________ Social Security Number ____________

Sex: (M) (F) Marital Status: (M) (S) (D) (W)

Occupation ____________________ Employer ____________

Insurance Company ____________ Group No. ________ Employer Name ____________

Guarantor ____________ Date of Birth ____/____/____ Relationship to Patient ____________

Person financially responsible for account ______________________________

Insured's I.D. No./SSN ______________________________

You were referred to us by: ______________________________

Person to contact for emergency ____________________ Phone Number ____________

Appointment Agreement

Appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least **24 hours notice** prior to canceling or rescheduling appointments. Patients who cancel or reschedule their appointment without proper notice will be assessed a $150.00 fee to offset the lost production time and estimated amount of time effort the staff has already spent preparing for the appointment. We look forward to accomplishing all of your treatment needs in a comfortable and caring environment.

Patient's Signature ______________________________

(PLEASE TURN OVER)

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics 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 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. I also permit the release of any information to or from my physicians as may be required.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment in full is due at time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% 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 ____________________________

Parent/Responsible Party's Signature_________________________________ Relationship to Patient _______________________

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