Patient Registration

Today's Date _____

First Name _____ Last Name _____ Middle Name _____Prefers to be called _____
Sex μ M μ F Birth Date _____ Age _____
Home Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work & Ext _____
Cellular/Mobile _____
Best Number to reach me on is _____ Best time of day is _____ Any other preference? _____
Social Security Number _____ Drivers License Number _____ State _____
E-Mail _____
Marital Status μ Single μ Married μ Divorced μ Separated μ Widowed Spouses Name _____
Occupation _____ or if Student μ Part Time μ Full Time Name of School _____
Referred to us by _____ Emergency Contact _____
If over 18 years of age – I consent to Livonia Dental Group talking to my parents regarding my treatment & account μ Yes μ No

Responsible Party if different than above:
First Name _____ Last Name _____ Middle Name _____Relationship to Patient _____
Sex μ M μ F Birth Date _____
Home Address _____ City _____ State _____ Zip _____
Phone: Home _____ Work & Ext _____
Cellular/Mobile _____
Best Number to reach me on is _____ Best time of day is _____ Any other preference? _____
Social Security Number _____ Drivers License Number _____ State _____
E-Mail _____
Marital Status μ Single μ Married μ Divorced μ Separated μ Widowed Spouses Name _____

Primary Insurance Information
Name of Insured _____ Relationship to Insured μ Self μ Spouse μ Child μ Other
Insured Social Security Number _____ Insured Birth Date _____
Employer _____ Employer's Address _____
Insurance Company _____ Ins. Co. Address _____

Secondary Insurance Information
Name of Insured _____ Relationship to Insured μ Self μ Spouse μ Child μ Other
Insured Social Security Number _____ Insured Birth Date _____
Employer _____ Employer's Address _____
Insurance Company _____ Ins. Co. Address _____

Consent:
The undersigned hereby authorizes Livonia Dental Group to take x-rays, photographs, study models or any other diagnostic aids deemed appropriate by Livonia Dental Group to properly treat the patient's dental needs. I authorize Livonia Dental Group to perform any and all forms of treatment, medication and therapy. I understand the use of anesthetic agents embodies a certain risk. I understand that I can ask for a complete recital of any possible complications. I authorize Livonia Dental Group to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Livonia Dental Group. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that such payments are due and payable at the time service are rendered unless a financial agreement has been made in writing. I understand that a finance charge can be added to any overdue balance.

Cancellation policy – a 24 hour notice must be given to cancel or change an appointment. We reserve the right to charge a $50 fee for a broken appointment with less than a 24 hour notice. After two broken appointments, we reserve the right to require a deposit in order to make another appointment. After a third broken appointment, we reserve the right to dismiss you from the practice.

Patient Signature (Parent of Child/Responsible Party) _____ Date _____