PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION:

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

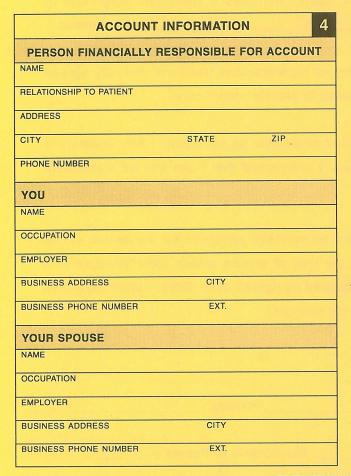
IF THIS

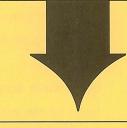
APPOINTMENT IS FOR YOUR CHILD

START HERE

DATE 1 NAME SPOUSE **ADDRESS** CITY STATE ZIP HOME PHONE NO. MALE FEMALE BIRTHDATE AGE DIVORCED WIDOWED MARRIED SINGLE SOCIAL SECURITY NO. DATE NAME ADDRESS STATE ZIP CITY HOME PHONE NO. BIRTHDATE AGE MALE FEMALE SCHOOL GRADE SOCIAL SECURITY NO. IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

PRI	MARY CARRIER					
INSURANCE COMP	PANY					
GROUP NO.						
EMPLOYEE						
DATE OF BIRTH	DATE EMPLOYED					
UNION OR LOCAL NO. EMPLOYEE NO. EMPLOYEE SOCIAL SECURITY NO.						
				EMPLOYEE SOCIAL	L SECURITY NO.	
					DNDARY CARRIER	
	ONDARY CARRIER					
SECO	ONDARY CARRIER					
SECO	ONDARY CARRIER					
SECO INSURANCE COMP GROUP NO.	ONDARY CARRIER					
SECO INSURANCE COMP GROUP NO. EMPLOYEE	DATE EMPLOYED					
SECO INSURANCE COMP GROUP NO. EMPLOYEE DATE OF BIRTH	DATE EMPLOYED					
SECO INSURANCE COMP GROUP NO. EMPLOYEE DATE OF BIRTH UNION OR LOCAL	DATE EMPLOYED NO.					





	GETTING TO KNOW YOU	3				
	IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE					
	NAME: RELATIONSHIP:					
	REFERRED TO US BY					
	YOUR FORMER ADDRESS					
	CITY STATE ZIP					
	PERSON TO CONTACT FOR EMERGENCY					
	PHONE NUMBER					
	ADDRESS					
	CITY STATE ZIP					
	CLOSEST RELATIVE NOT LIVING WITH YOU					
	PHONE NUMBER					
	ADDRESS ,					
	CITY STATE ZIP					

1					
CONSENT FOR TREATMENT					
1.	I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any				
	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.				
	the state of the second				
	Lastly, I agree to be responsible for payment for 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				
	a 1-1/2% late charge (18% APR) may be added to my account.				
Patient _	Date Witness				
Parent or	Responsible Party Relationship to Patient				