ROBERT A. PALMER, JR. D.D.S.
JAKE P. O'BRIEN D.D.S

A PROFESSIONAL DENTAL CORPORATION

FAMILY AND COSMETIC DENTISTRY

PATIENT REGISTRATION

Welcome to our office. Thank you for providing the following confidential information.

Name____ Home Telephone____

Mailing Address____________________________________ Place of Employment____

City and State _____________________________________ Office Telephone ____

Zip Code___________________________________ Cell or Alternate ____

Date of Birth _____________________________________ Male___ Female___ Social Security__________________________________

Email Address ____ Would you like to receive email and text message reminders? Y/N

Whom may we thank for referring you to the office? ____

EmergencyContacts____

In case of emergency, notify _______________________________Relationship____

Home Telephone ____ Alternate____

Payment Information ____

Name of responsible party (if other than patient)____

Address ____ **Method of Payment**

City, State, Zip ____ Cash/ Check ______________

Home Telephone _______________________________________ Mastercard/ Visa__________

Place of Employment ___________________________________ Insurance _______________

Office Telephone ______________________________________

Dental Insurance (Primary)

Insured's Name _______________________________________

Insured's D.O.B. _______________________________________

Insured's SS No. _______________________________________

Place of Employment __________________________________

Insurance Co. ______________________

Dental Insurance (Secondary)

Insured's Name ____

Insured's D.O.B. ____

Insured's SS No.____

Place of Employment____

Insurance Co. ____

Consent

The undersigned hereby authorizes the Doctor and Hygienist to take X-rays, study models, Photographs, or any other diagnostic aids deemed appropriate by the Doctor's thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated and understand the use of anesthetic agents embodies a certain risk. **I understand that my dental insurance is a contract between me and the insurance carrier, and not the insurance carrier and ther Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless financial agreements have been made.** I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be applied to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be applied added to any overdue balance. **There will be a $ 25.00 fee for any appointment that is not canceled without a 24 hour notice.**

Signature: ____ Date: ____