ADULT **REGISTRATION**

Charles F. Betts, Jr., D.M.D., P.C. Date_____

Patient Name _____ Preferred name _____
Last, First Middle

Sex: M __ F__ Marital Status: _____ Birthdate_____ SS#: _____

Address_____ Zip_____

Best Daytime Phone: _____ Would you like to receive texts to this number? _____

Other Phone: _____ E- Mail Address _____

Employer Name _____Occupation _____

How did you find out about our office?_____

Emergency Contact_____Phone_____

List any current dental problems. _____

_____

What are your concerns? ***Circle as many as applicable:***

Pain Avoidance Appearance Losing Teeth Gum/Periodontal Disease Cavities

Oral Cancer General Health Routine Checkup Cleaning

Other Concerns?_____

CONSENT FOR SERVICES SIGNATURE:

I give my consent to any advisable and necessary dental procedure, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment. I also acknowledge that I have been offered a copy of the office's "Notice of Privacy Practices."

For patients with dental insurance: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law. To the extent permitted by law, I consent to the use and disclosure of my protected health information to carry out payment activities in connection with insurance claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Charles F. Betts, Jr., D.M.D., P.C.

I understand that, unless payment is made in full at the time of service, I am opening an account with this office subject to credit inquiry.

I WILL PAY TODAY BY: Cash_____Check _____Credit card_____

X_____