DONALD I. CADLE, JR., D.M.D.

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date			
Name			
Address			
City	State	Zip	
Home Phone	Cell Phone		
Email			
Birthdate	Age	Male	Female
Height		Weight	
Married	Single	Divorced	Widowed
Social Security No.			

YOU

Occupation/Previous Occupation	
Employer	
Business Address	City
Business Phone No.	

YOUR SPOUSE

Name	
Occupation	
Employer	
Business Address	City
Business Phone No.	

ACCOUNT INFORMATION

Person Financially Responsible For Acct.

Name		
Relationship To Patient		
Address		
City	State	Zip
Home Phone No.		

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Co. Name	
Insurance Co. Address	
Insurance Co. Phone	
Group # (Plan, Local or Policy #)	
Insured's Name	Relation
Insured's Birthday / /	Insured's SS #
Insured's Employer	
Date Employed	

SECONDARY CARRIER

Insurance Co. Name	
Insurance Co. Address	
Insurance Co. Phone	
Group # (Plan, Local or Policy #)	
Insured's Name	Relation
Insured's Birthday / /	Insured's SS #
Insured's Employer	

GETTING TO KNOW YOU

Is another member of your family or a relative a patient at our office? Name:	Relation	
Who may we thank for referring you?		
Your Former Address		
City	State	Zip
In the event of an emergency, is there someone who lives near you that we should contact? Their Name:	Relation	
Work #	Home #	

PLEASE TURN OVER AND SIGN

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 and 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.

4. I will allow Dr. Cadle to photograph and use for educational purposes any aspect of my dental conditions or treatment procedures, and further will allow him permission to discuss my condition with my physician and request medical information from him.

5. Lastly, I agree to be responsible for payment of 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 _________________