Registration

Responsible Party Signature:

X

Patient Information

Full Name: ______________________________________

Address: ____

City: ____________________ State: _____ Zip:_________

Home Phone: ____________________________________

Cell Phone: ______________________________________

Birth Date: _____________ Driver License: ___________

SSN: __________________________ **Gender**: M ☐ F ☐

Marital Status: Married ☐ Single ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor ☐

Employer Name & Address: ______________________

____

Work Phone: ____________________________________

Employment Status: Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐

Student Status: FT ☐ PT ☐

E-Mail:____

Yes, I would like to receive email correspondences ☐

Whom may we thank for referring you?

____

Emergency Contact

Name: _____________________

Relation: ________________ Phone: ________________

Responsible Party (person financially responsible for account if other than patient)

Name: __________________________ Relation:__________

Birth Date: _____________ Driver License: ____________

Address: ____

____

Phone #: ________________ Work #: ________________

Employer: ______________________________________

Primary Insurance Information

Name of Insured: __________________________________

Birth Date: ______________ Relation: ________________

Insurance Co: _____________________________________

SSN: ____________________ Grp #: __________________

Policy #: ____________________ ID #: _______________

Employer Name & Address (if other than patient):

____

Secondary Insurance Information

Name of Insured: __________________________________

Birth Date: _________________ Relation: _____________

Insurance Co: _____________________________________

SSN: ___________________ Grp #: ___________________

Policy #: ___________________ ID #: _________________

Employer Name & Address (if other than patient):

____

____

Dental Information

Reason for today's visit: ______________________________________ Date of last dental care: __________________

Are you having pain or discomfort at this time? Yes ☐ No ☐ Do your gums bleed when you brush? Yes ☐ No ☐

Check(X) if you have had problems with the following: Bad breath ☐ Grinding teeth ☐ Clicking or popping jaw ☐ Loose teeth or broken fillings ☐ Sensitivity to hot, sweets, or cold ☐ Periodontal Treatment ☐ Sores in your mouth ☐

AUTHORIZATION AND CONSENT

I certify that I, and /or my dependents(s) have insurance coverage with ____________________________________ and authorize payments of insurance benefits otherwise payable to me, directly to __***Francisco Mondragon D.D.S***__.

I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

CONSENT

The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (patient's name) _______________________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

_______________________________________ _______________________________________ __________

Print Name (patient, parent, guardian or representative) **Signature** (patient, parent, guardian or representative) **Date**