PATIENT REGISTRATION

DATE		
LAST NAME	FIRST	M.I.
PREFERS TO BE CALLED BY		
ADDRESS		
CITY	STATE	ZIP

HOME PHONE NO.	CELL	WORK	
BIRTHDATE	AGE	MALE ☐	FEMALE ☐
MARRIED ☐	SINGLE ☐	DIVORCED ☐	WIDOWED ☐
SOCIAL SECURITY NUMBER			
YOU WERE REFERRED TO US BY			
EMAIL ADDRESS:			
PERSON TO CONTACT IN CASE OF EMERGENCY NAME	PHONE NUMBER		

DENTAL INSURANCE	
PRIMARY INSURANCE	
INSURANCE COMPANY	GROUP NO.
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO	INSURED'S SOCIAL SECURITY NO
SECONDARY INSURANCE	
INSURANCE COMPANY	GROUP NO.
EMPLOYER NAME	INSURED'S NAME
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO	INSURED'S SOCIAL SECURITY NO

ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME	OCCUPATION	
EMPLOYER'S NAME	ADDRESS	
CITY	PHONE NO.	
YOUR SPOUSE		
NAME	OCCUPATION	
EMPLOYER'S NAME	ADDRESS	
CITY	PHONE NO.	

I hereby authorize Drs. Karen Lennon and Christopher Mar D.D.S., PA, (hereafter collectively referred to as "Practice") to use and disclose the entire medical/dental record concerning myself in accordance with the Notice of Privacy Practices (NOPP), available upon request. I have been given the opportunity to review the NOPP, and to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including, but not limited to negligence) arising out of or occurring under this Consent.

Please send a copy of my records (including information from other health-care providers that may contain) to: ____

____

____

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and 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.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. 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. If required, I also understand a check of my credit history may be made.

6. Mar & Lennon Dentistry shall have the authority to charge and assess collection costs and expenses, including reasonable attorneys' fees, and penalties and interest for the late payment or nonpayment thereof.

Patient's Signature ___________________ **Date** _______________ **Witness** ___________________________

Patient/Responsible Party's Signature ______________________ **Relationship to Patient** _____________