# *Welcome*

PRECISION DENTAL MKE

# Patient Registration

## About You

Today's Date: _____

Patient's name: _____

What you prefer to be called: _____

Birth Date: _____ Age: _____

SS#: _____

Mailing Address: _____

_____

Home phone number: _____

Work phone number: _____

Cell phone number: _____

Email Address: _____

Referred by: _____

Employer: _____

Employer Address: _____

Occupation: _____

Status: ☐ Minor

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____

Do you have children: ☐ Yes ☐ No

## Account Information

Person Ultimately Responsible for Account

Name: _____

Relation: _____

Billing Address: _____

_____

SS#: _____

Driver's license number: _____

Work phone number: _____

Payment method: ☐ Cash ☐ Check ☐ Credit Card

I hereby authorize assignment of my insurance rights and benefits a directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please initial: _____

## Insurance Information

**Primary Dental Insurance**

Co. name: _____

Address: _____

Phone number: _____

Insured ID#: _____

Group #: _____
(Plan, Local, or Policy #)

Insured's name: _____

Relation: _____

Date of birth: _____

Insured's employer: _____

**Secondary Dental Insurance**

Co. name: _____

Address: _____

Phone number: _____

Insured ID#: _____

Group #: _____
(Plan, Local, or Policy #)

Insured's name: _____

Relation: _____

Date of birth: _____

Insured's employer: _____

## Emergency Contact

Whom shall we contact: _____

Relation: _____

Home phone number: _____

Work phone number: _____

Cell phone number: _____

Who is your Medical Doctor: _____

Medical Doctor's phone number: _____

Complete Consent Form on other side. Please turn over.

PRECISION DENTAL MKE

# Consent Form

## Operational Consent

**Our use of Dental Health Information:** By signing this form, you will consent to our use of your dental records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

**Persons involved in care:** By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care. Please print.

_____ _____

_____ _____

_____ _____

You have a right to revoke this consent by contacting our office at (414) 764-5770. A form will be sent to you. Thank you.

## Consent for Treatment

1. I hereby authorize Precision Dental MKE or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by Precision Dental MKE to make a thorough diagnosis of (patient's name) _____'s dental needs.
2. Upon such diagnosis, I authorize Precision Dental MKE 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 anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can request a complete recital of any possible complications.
4. I give consent to Precision Dental MKE 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 only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection on my personal health information is available for my review.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's signature:_____ Date _____

Parent/Responsible party: _____ Date _____

Relationship to patient: _____ Witness:_____