JEFF TOLLETT DDS
Dentistry made personal

Patient Registration

Age__________ Date__________

Patient's Name____ Date of Birth__________ ☐ Male ☐ Female

Last First Initial MM-DD-YY

If Child: Parent's Name______________________________

How do you wish to be addressed______________________

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence: Street ______________________________
City__________________________ State___ Zip__________

Contacts (please check preferred method)
☐ Home Phone ____________ ☐ Cell Phone ____________
☐ Work Phone ____________ ☐ Ok to text cell phone?
☐ email ______________________________

Patient Employer______________________________
Present Position __________________ How Long__________

Spouse / Parent Name______________________________
Spouse Employer______________________________
Present Position __________________ How Long__________

Who is responsible for the account ?__________________
Driver's License #______________________________

Method of Payment ☐ Insurance ☐ Cash ☐ Credit Card

Purpose of Visit______________________________

Other Family members in the practice__________________

Whom may we thank for the referral__________________

Patient /Parent SSN______________________________

Spouse/Parent SSN______________________________

Emergency Contact Name/Number ____________________
____

PRIMARY DENTAL INSURANCE

Employee Name __________________ Date of Birth__________

Relationship to Patient ______________________________

Employer Name ______________________________

Insurance Company ______________________________

Address______________________________
____

Telephone______________________________

Policy #______________________________

Group #______________________________

SSN ______________________________

SECONDARY DENTAL INSURANCE

Employee Name __________________ Date of Birth__________

Relationship to Patient ______________________________

Employer Name ______________________________

Insurance Company ______________________________

Address______________________________
____

Telephone______________________________

Policy #______________________________

Group #______________________________

SSN ______________________________

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.______________________________
My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or the payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor. I attest to the accuracy of the information on this page.

X PATIENT'S OR GUARDIAN'S SIGNATURE DATE
____

S. CHRISTIAN BAHM, D.D.S. • JEFF TOLLETT, D.D.S.
GENERAL AND COSMETIC DENTISTRY

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