Masterpiece Family & Cosmetic Dentistry

Minor/Dependant Patient Registration

The following information is for our records only and will be considered confidential.

Name_____ Preferred Name_____
Last First Middle Initial

Address_____City_____ State____ Zip_____

Birthdate_____ Pt SSN_____

Home Phone_____ Cell Phone_____

E-Mail Address_____ Would you "like" us on Facebook? Y N

Refer us a new patient and you may win the lottery!

How may we best contact you? (Circle all that apply) Home Phone Answering Machine
Cell Phone Voice Mail Work Phone E-Mail Text Message

Are any immediate family members current patients of record? Yes_____ No_____

If so, Name_____ Relationship to patient_____

Person Responsible for Account_____ Phone_____
(Must be available to sign documentation)

Responsible Person's SS #_____

Address_____ City_____ State____ Zip_____

Who may we contact in case of emergency (other than parent/guardian)?_____

Relationship to Patient_____Phone_____

Parent/Guardian Name _____SS#_____
(Please Provide Documentation for Guardian – example: Court paperwork, Custody papers)

Parent/Guardian Address_____

Parent/Guardian Birthdate_____ Parent/GuardianEmployer_____Phone_____

Can parent/guardian be contacted at work? Yes_____ No_____

Pts Spare Time Activities or Hobbies_____

Who may we thank for referring you to this office?_____

Parent/Guardian will be paying by: Cash___ Check___ Credit Card___ Debit Card____

Care Credit_____ Lending Club_____ Wells Fargo _____ Other (list)_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, including Adjunctive Comprehensive Services. (List available upon request). I have reviewed all of the above information and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes of the above information.

Parent/Guardian Signature_____ Date_____

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Permission to Bring Minor Patient for Dental Treatment

Minor
Patient's Name_____DOB_____

Patient's Address_____Phone_____

_____

(Please Circle One) Are you the: Parent Legal Guardian

Name of Parent/Legal Guardian_____DOB_____

Driver's License/ID ID #_____ State Issued_____

Parent/Legal Guardian Address_____Phone_____
If different from minor patient's

_____

Please list names and phone numbers of person(s) who may bring minor patient to be treated:

☐ Patient may be dropped off for treatment ☐ Patient may drive/bring themselves - if of age

Name _____Phone_____

Name _____Phone_____

Name _____Phone_____

Name _____Phone_____

I certify that I am the parent or legal guardian of the minor patient listed above and that I have full authority over his/her dental care. I understand that the payment must be sent with the patient for all treatment to be rendered. I agree that the person(s) listed above have permission to bring the minor patient for treatment and I give my permission for the treatment scheduled to be completed. The information above is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

_____ _____

Signature of Parent/Guardian Date