Dr. Beverly Morris, D.D.S.

Registration Form

Date: _____

Patient Name: _____ □Male □Female
Last First Initial

How would you like to be addressed? _____

Date of Birth: _____ □Married □ Single □Divorced □Minor Age: _____

If Minor, Parents Name: _____

Address: _____
Street apt# City State zip

Phone: (Home) _____ (Cell) _____ (Business) _____

Other Family Members in this practice: _____

_____

Whom may we thank for this referral: _____

Someone to notify in case of emergency not living with you:

_____

Insurance Information

Employee Name: _____

Relationship to patient: _____Date of Birth: _____

Employer Name: _____

Phone: _____ S.S. # _____

Address: _____

Name of Insurance Co.:_____

Drivers License No. _____

Consent/Authorization

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist use and disclosure of my/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. My consent shall be effective until I revoke it in writing. **I consent to the disclosure of my/my child's records to the following persons who are involved in my/my child's care for 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 insurance carrier or 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 all services not paid by my dental care payor.

I understand that photographs, x-rays, and other records may be taken during the course of my treatment. I give my permission for such items to be used for purposes of research, education, publication in professional journals, and/or website of Dr. Beverly Morris. If you decline to consent to the use of these items please mark the following box & initial before signing this form.

□ I decline consent for use of my photographs, x-rays and other records. Initial _____

Patient or Guardians Signature: _____ Date: _____