PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION.

ABOUT YOU

DATE: _____

LAST NAME: _____ FIRST: _____ M.I.: _____

PREFERS TO BE CALLED BY: _____

ADDRESS: _____

CITY_____ STATE _____ ZIP_____

PHONE: _____WORK: _____

CELL: _____ E-MAIL _____

BIRTHDATE: _____ AGE: _____ MALE: _____ FEMALE: _____

MARRIED: _____ SINGLE: _____ DIVORCED: _____ WIDOWED: _____

SOCIAL SECURITY NO._____ D.L.# _____

SPOUSE OR PARENT

HIS/HER NAME: _____ BIRTHDATE: _____

SOCIAL SECURITY NO._____ D.L.# _____

EMPLOYER: _____

WORK: _____ CELL: _____

PERSON RESPONSIBLE FOR ACCOUNT

HIS/HER NAME: _____ RELATIONSHIP: _____

SOCIAL SECURITY NO._____ BIRTHDATE: _____

WORK: _____ CELL: _____ D.L.# _____

BILLING ADDRESS: _____

EMERGENCY CONTACT

HIS/HER NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____ WORK: _____ CELL: _____

CLOSEST RELATIVE NOT LIVING WITH YOU

HIS/HER NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME: _____WORK: _____ CELL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO. NAME: _____ GROUP NO. _____

INSURANCE CO. PHONE: _____ ID NO. _____

INSURED NAME: _____ BIRTHDATE: _____

INSURED SOCIAL SECURITY NO. _____ EMPLOYER NAME: _____

SECONDARY INSURANCE

INSURANCE CO. NAME: _____ GROUP NO. _____

INSURANCE CO. PHONE: _____ ID NO. _____

INSURED NAME: _____ BIRTHDATE: _____

INSURED SOCIAL SECURITY NO. _____ EMPLOYER NAME: _____

ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE DR. LUNT OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED NECESSARY BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF DENTAL NEEDS.

2. UPON SUCH DIAGNOSIS, I AUTHORIZE DR. LUNT AND STAFF TO PERFORM ALL RECOMMENDED TREATMENT AS MUTUALLY AGREED UPON.

3. I AGREE TO THE USE OF ANESTHETICS, SEDATIVES AND OTHER MEDICATION NECESSARY FOR TREATMENT. I FULLY UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES CERTAIN RISKS. I UNDERSTAND THAT I CAN ASK FOR A COMPLETE RECITAL OF ANY POSSIBLE COMPLICATIONS.

4. 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 1-½% LATE CHARGE (18% APR) MAY BE ADDED TO MY ACCOUNT. IF REQUIRED, I ALSO UNDERSTAND A CHECK OF MY CREDIT HISTORY MAY BE MADE.

5. CANCELLATIONS NOT CONFIRMED WITHIN THE 48 HOUR REQUIREMENT OR FAILURE TO ATTEND YOUR SCHEDULED APPOINTMENT, MAY RESULT IN A CHARGE TO YOUR ACCOUNT. FOR CURRENT POLICY PLEASE CONTACT THE FRONT DESK.

6. I ACKNOWLEDGE THAT I HAVE RECEIVED FROM DR. DAVID P. LUNT D.D.S. A COPY OF THE DENTAL MATERIALS FACT SHEET DATED OCTOBER 2001.

7. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PATIENT"S SIGNATURE _____DATE_____WITNESS_____

PATIENT/RESPONSIBLE PARTY'S SIGNATURE_____RELATIONSHIP _____