Patient Registration Form

Welcome to Keyser Dentistry! To provide you with the best possible care, please complete this patient registration form. All information is completely confidential.

Date:_____
Patient Name:_____
Medical Alert:_____
Address:_____
Preferred Phone:_____
Email:_____
Birthdate:_____

☐ ***Married*** ☐ ***Single*** ☐ ***Divorced*** ☐ ***Separated***

Is another member of your family a patient?_____
Name:_____
Relationship:_____
Emergency Contact:_____
Phone:_____
Address:_____
Closest Relative Not Living with You:_____
Phone:_____
Address:_____

Account Information:

Responsible Party:_____
Relationship to Patient:_____
Phone:_____
Address:_____
Personal Occupation:_____
Employer:_____
Employer Address:_____
Phone:_____
Spouses Name:_____
Employer:_____
Employer Address:_____
Phone:_____

- I hereby authorize Dr.Keyser or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Keyser to make a thorough diagnosis

-Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care

-I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using these agents and undergoing dental treatment embodies certain risks. I understand that I can ask for a complete recital of The Risks of General Dentistry

-I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payments are due at the time of service unless other arrangements have been made.

Patient's Signature: ____ _Date:
Witness Signature:
Parent/Responsible Party Signature:
Relationship to Patient: