YourBeautifulSmile.com

Your Beautiful Smile
FAMILY DENTISTRY

PATIENT REGISTRATION

Welcome! In our private care practice our primary aim is to deliver the highest quality of care and to provide the very best of service. This will always be the standard. Once an appointment is made, please remember this time has been specifically reserved for you. Reasonable notice (48 business hours) should be given if you are unable to keep the appointment.

Patient Name: _____ Today's Date: _____

Patient's Date of Birth: _____ If Child, Parent's Name: _____

Home Number: _____ Cell Number: _____ Work Number: _____

E-mail Address: _____ Social Security Number: ____-___-_____

Address: _____ City: _____

State: _____ Zip: _____ Who may we thank for referring you? _____

Emergency contact: Name: _____Relationship_____ Phone: _____

Person responsible for payment: _____

Dental Insurance Information

Dental Insurance Company: _____ Dental Insurance Phone #: _____

Dental Insurance Address: _____

Group Number: _____ Identification number: _____

Subscriber name: _____ Employer's Name: _____

Subscriber's Social Security #: _____ Subscriber's Date of Birth: _____

Thank you for your interest in our services. Please read the following information and sign where indicated.

1) **I hereby authorize Dr. Silberstein and designated staff to take radiographs, photographs, and complete any other diagnostic aids deemed appropriate by Dr. Silberstein to make a thorough diagnosis of my dental needs.**
2) **Upon such diagnosis, I authorize Dr. Silberstein to perform all recommended treatment mutually agreed upon with me and to employ such assistance, as required, to provide proper care.**
3) **I agree to the use of anesthetics, sedatives and other medication as necessary. I understand that using anesthetic agents embodies certain risks. I understand that I may ask for a complete recital of any possible complications.**

Signed: _____Date: _____