Patient Registration Date:_____________

Name:_______________________________________

Date of Birth:_____________________ Age:________

I prefer to be called:____________________________

Legal Guardian(s):_____________________________

____

Gender: ☐ Male ☐ Female

Address:_____________________________________

City:____

State:_____________ Zip Code:_________________

Home Phone:__________________________________

Work Phone:__________________________________

Cell Phone:___________________________________

E-mail:_______________________________________

I would like to receive appointment reminders by:

☐ Mail ☐ Text Message ☐ E-Mail

☐ Home Phone ☐ Work Phone ☐ Cell Phone

Emergency contact:

Name:___________________________

Address:_________________________

____

Phone:__________________________

Relationship:_____________________

I hereby authorize you to share my medical information with the following people:

____

____

It's ok to leave voicemail messages regarding my treatment: ☐ Yes ☐ No

Best Appointment Times: __________ AM / PM

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Who may we thank for referring you?

☐ Friend/Family ____________________________

☐ Website/Internet___________________________

☐ Newspaper Ad____________________________

☐ Sign_____________________________________

☐ Other____________________________________

Insurance Information:

Responsible Party:__________________________

Name of Insured:___________________________

Relationship to insured:______________________

Insurance Carrier:__________________________

Group #:___________ Policy#:_______________

Employer:_________________________________

Social Security:____________________________

General consent.

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
2. 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.
3. I agree to the use of anesthetics and other medications as necessary for the completion of my treatment. I fully understand that using anesthetic agents entails certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient or Guardian:

____

420 Village Walk Drive Holly Springs, NC 27540 919.567.7484 campbellfamilydentistry@gmail.com