KEVIN J. DAILY, D.D.S., INC.

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial _____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name _____ Middle Initial _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc. Security: _____ Driver's Lic.: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: ____ Soc. Security: _____ Driver's Lic.: _____

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Insurance Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to a thorough diagnosis of (Name of patient)_____ 's dental needs

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

3. I agree to the use of anesthetic, sedative and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice full outlining the protection of my personal health information is available.

5. 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 recieved by agreed upon dates, I understand that a $1^{1/2}\%$ late charge (18% APR) may be added to my account.

Patient's Signature _____ Date _____

Patient/Responsible
Party's Signature_____ Relationship to Patient _____