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

PATIENT REGISTRATION

Patient Is:	ID:	Chart ID:			
Responsible Party (if someone other than the patient) First Name: Last Name Middle Initial	First Name:	Last Name:	Middle Initial		
Responsible Party (if someone other than the patient) First Name: Last Name	Patient Is: ☐ Policy Hold	der Preferred Name:	-		
First Name: Last Name	☐ Responsibl	le Party			
Address:	Responsible Party (if so	omeone other than the patient)			
City, State, Zip:			ddle Initial		
Home Phone:	Address:	Address 2:			
Birth Date: Soc. Security: Driver's Lic: Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Secondary Insurance Policy Holder Secondary Insurance Policy Holder Secondary Insurance Secondary Insurance Policy Holder Primary Insurance Policy Holder Secondary Insurance Policy Holder Primary Insurance Policy Holder Primary Insurance Policy Holder Pager: Pag	City, State, Zip:				
Responsible Party is also a Policy Holder for Patient	Home Phone:	Work Phone: Ext: Cell:			
Patient Information Address:	Birth Date:	Soc. Security: Driver's Lic.:	Driver's Lic.:		
Address:	☐ Responsible Party is a	also a Policy Holder for Patient	ince Policy Holder		
City, State, Zip:	Patient Information				
City, State, Zip:					
Home Phone:					
Sex: Male Female Marital Status: Married Single Divorced Separated Wido Birth Date: Age: Soc. Security: Driver's Lic.:	· ·				
Birth Date: Age: Soc. Security: Driver's Lic:: Section 2 Section 3	-				
Section 2		· · · · · · · · · · · · · · · · · · ·			
Employer Status:	<i></i>				
Student Status:	Section 2	Section 3			
Employer ID: Pref. Pharmacy: Primary Insurance Information	Employment Status:	☐ Full Time ☐ Part Time ☐ Retired Additional Comments:			
Carrier ID: Pref. Hyg.:	Student Status: 🗆 F	Full Time			
Primary Insurance Information Name of Insured: Insured Soc. Sec.: Employer: Address: Address 2: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: Insured Soc. Sec.: Insured Birth Date: Insured Soc. Sec.: Insured Birth Date:	Employer ID:	Pref. Pharmacy:			
Name of Insured: Insured Soc. Sec:: Insured Birth Date: Employer: Address:: Address 2: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: Relationship to Insured: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: Employer: Address: Address: Address: Address: Address: Address: Address: Address 2: Insured Birth Date:	Carrier ID:	Pref.Hyg.:			
Name of Insured: Insured Soc. Sec:: Insured Birth Date: Employer: Address:: Address 2: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: Relationship to Insured: City, State, Zip: Secondary Insurance Information Name of Insured: Insured Birth Date: Insured Birth Date: Insured Birth Date: Insured Birth Date: Insured Company: Address:					
Insured Birth Date: Employer: Insurance Company: Address: Address 2: City, State, Zip: City, State, Zip: Secondary Insurance Information Name of Insured: Relationship to Insured: Self Spouse Child Graph Insured Soc. Sec.: Insured Birth Date: Employer: Insurance Company: Address: Address 2: Address 3:					
Employer:		•	☐ Child ☐ Other		
Address:	Insured Soc. Sec.:	Insured Birth Date:			
Address 2: Address 2: City, State, Zip: City, State, Zip: City, State, Zip: Relationship to Insured: Self Spouse Child Relationship to Insured: Insured Birth Date: Insured Birth Date: Address: Address: Address 2:	Employer:	Insurance Company:			
City, State, Zip: Secondary Insurance Information Name of Insured: Insured Soc. Sec.: Employer: Address: Address 2: City, State, Zip: Relationship to Insured: Self Spouse Child Insured Birth Date: Address 2: Address 2:	Address:	Address:			
Secondary Insurance Information Name of Insured: Insured Soc. Sec.: Employer: Address: Address 2: Relationship to Insured: Insurance Company: Address 2: Address 2:	Address 2:	Address 2:			
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Name of Insured: Relationship to Insured: Self Spouse Child Insured Soc. Sec.: Insured Birth Date: Employer: Insurance Company: Address: Address: Address 2:					
Insured Soc. Sec.: Insured Birth Date: Employer: Insurance Company: Address: Address: Address 2:	Secondary Insurance II	Information ————————————————————————————————————			
Employer:	Name of Insured:	Relationship to Insured: Self Spouse	☐ Child ☐ Other		
Address:	Insured Soc. Sec.:	Insured Birth Date:			
Address:	Employer:	Insurance Company:			
Address 2: Address 2:			Address:		
City Care 7in	Address 2:				
City, State, Zip: City, State, Zip:	City, State, Zip:	City, State, Zip:			

Consent For Treatment

1.	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 S	Signature Date	
Patient/Responsible Party's Signature Relationship to Patient		