

Choice Dental Centre of Greenwood

Michelle Lumsdon, D.D.S.

PATIENT REGISTRATION AND CONSENT

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ - _____ Work Phone () _____ - _____ Cell Phone () _____ - _____

Date of Birth ____/____/____ Social Security # _____

Marital Status: M / S/ D/ W E-Mail address: _____

Person responsible for the account _____

Date of Birth ____/____/____ Social Security # _____

Dental Insurance Yes No Secondary Insurance Yes No

Name of insured _____ Relationship to Insured _____

Employer _____ Insurance company _____

Social Security # _____ Or ID # _____ Date of Birth ____/____/____

Telephone number of the insurance company _____ Group Number _____

Emergency Contact _____ Relationship to Patient _____

Emergency Number () _____ - _____ Cell Phone () _____ - _____

Consent for treatment:

The undersigned hereby authorizes Dr. Lumsdon or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I further authorize Dr. Lumsdon or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I understand that the use of any anesthetic agents involves certain risks. I understand the responsibility for the payment of dental services provided in this office for my dependents or myself is mine, due and payable at the time of services rendered. Insurance will be filed as a courtesy. Estimations are based on information from your insurance company. They are not a guarantee of payment. Regardless of financial arrangements the full responsibility of payment is mine. I further understand that any finance charges, refilling fees, collection charges, or attorney fees may be added to any overdue balance. I also assign all insurance benefits to Dr. Lumsdon. Please note that our HIPPA policy is available for your review upon request. A copy of the policy is also displayed in our reception area

Patient Signature (Parent of Child) _____ Date ____/____/____