

# Because its your Smile. Marcus Whitmore, DDS

## Your Registration

Name (first, MI, last) \_\_\_\_\_

How would you like to be addressed? \_\_\_\_\_

How did you hear about Dr. Whitmore? \_\_\_\_\_

Address \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Mobile \_\_\_\_\_ Email \_\_\_\_\_

Birth date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Social Security No. \_\_\_\_\_

Emergency Contact Name/No \_\_\_\_\_

### About You ...

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

### Your Spouse ...

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

### Primary Dental Insurance ...

Primary Insurance Company \_\_\_\_\_

Insurance Phone No \_\_\_\_\_

Group No \_\_\_\_\_

Employer \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's ID No. \_\_\_\_\_

Insured Social Security No. \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

### Secondary Dental Insurance ...

Primary Insurance Company \_\_\_\_\_

Insurance Phone No \_\_\_\_\_

Group No \_\_\_\_\_

Employer \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's ID No. \_\_\_\_\_

Insured Social Security No. \_\_\_\_\_

Insured's Birth Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



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## Your Consent

I hereby authorize Dr. Marcus Whitmore and his team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Whitmore to make a thorough diagnosis of (Your Name) \_\_\_\_\_ dental needs.

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

I agree to the use of anesthetics, sedatives, and other medication 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.

I give consent to Dr. Whitmore and his team 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 fully outlining the protection of my personal health information is also available.

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. If insurance is filed for me, I agree to pay what insurance does not cover with in 30 days.

Your Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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