Dr Samuel Barr

REGISTRATION FORM

Patient Information **Date_______________**

Name:____ I Prefer to be called___________________

Address:____City:________________State:___Zip_
____

Phone (_______)__________________ Work Phone (_____) _________________

Cell Phone (_______)_____________________

The best time to contact me:________________ on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:________________ Social Security Number:____________________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School________________________________

City/State_______________________________ ☐ FT ☐ PT

Spouse or Parent's Name:_______________________________________

Whom may we thank for referring you ____

Person to contact in case of emergency_______________________________________
Phone____________________________

Email Address____

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:____

Address:____

City:___________________________________ State:___________ Zip:______________

Phone: (____)______________________

Employer___________________________ Work Phone (____)___________________

SSN#_______________________________

Dr Samuel Barr

I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by Dr Barr to make a thorough diagnosis of (patient's name) _______________________'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives 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.

I have been given the opportunity to read and review the Federal (HIPAA – Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time. Initial __________

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsibly for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge per month (18% APR, $3.00 minimum) and any expenses such as attorney fees, if engaged for the purpose of collections, may be added to my account.

Patient or Guardian
Signature____Date_________________