

DR. LAWRENCE FOX

— AND ASSOCIATES —

Cosmetic • Implant • General

Dentistry

PATIENT REGISTRATION

LAWRENCE T. FOX, D.D.S. • 5200 LYNNGATE COURT • BURKE, VIRGINIA 22015 • 703/978-5253

Please complete the following confidential information

Date _____ Home Phone _____

Patient _____

Last Name

First Name

Initial

Preferred Name

Street _____ Apt. # _____

City _____ State _____ Zip _____ Social Security # _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Fax # _____ E-mail _____

Spouse Name _____ Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

SSN of Insured _____ Birthdate of Insured _____

Person holding Insurance _____ Place of Employment _____

Relationship to Patient _____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

(Please complete other side)

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 make 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 assistance as required to provide proper care.
3. 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.
4. 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 received by agreed upon dates, I understand that a 1-1/2 % late charge (18% APR) may be added to my account.
5. In the event my account becomes delinquent, I understand that I am responsible to pay actual and reasonable collection costs and reasonable attorney fees.

Patient Signature _____ Date _____