

LAWRENCE T. FOX, DDS

Cosmetic ♦ Laser ♦ Implant ♦ General

Dentistry

PATIENT REGISTRATION

LAWRENCE T. FOX, D.D.S. • 5200 LYGATE 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 _____

Cell # _____ E-mail _____

Spouse Name _____ Occupation _____ Business Phone _____

Primary Dental Insurance

Subscriber Name _____ Relationship to Patient _____

SSN of Insured _____ Birthdate of Insured _____

Plan Name _____ Insurance ID# _____

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.

Patient's Name

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.

5. In the event my account becomes delinquent, I understand that I am responsible to pay actual court costs any attorney's fees that may be added to my account.

Patient Signature _____ Date _____
(Must be signed by responsible party)