PATIENT REGISTRATION

E.M. Makhoul, DDS

(Please Print)

Patient Name_____Preferred Name_____
First Last Middle

Address_____
Street Address/Apartment# City State Zip Code

Home#_____Work#_____Ext_____Cell#_____

____Male ____Female ____Single ____Married ____Divorced ____Separated ____Widowed

Birth Date:_____Soc. Sec. #_____Driver's lic._____

E-mail Address_____

If you are a College Student, Status_____Full Time or _____Part Time

College Name & City_____

Occupation_____

Employer Name_____

Bus. Address_____
Street Address/Suite# City State Zip Code

Whom may we thank for referring you to our office?_____

Is another family member, relative or friend, a patient at our office?_____

Emergency contact_____
Name & Tel# Relationship

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I, the undersigned Responsible Party, hereby authorize Dr Makhoul and Staff to take any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of Patient's dental needs. I further authorize and consent that Doctor choose and employ such assistance as deemed fit by law. I authorize the release of any information relating to Patient's records to and from Dr Makhoul, to and from third party payers, other healthcare professionals, and other entities as deemed necessary by this office and fit by law. In case of insurance, I do authorize my insurance company to make payments directly to Dr Makhoul for all benefits otherwise payable to me, and authorize the use of this signature for all insurance submissions. I understand that less than forty eight hour cancellation notices will be charged one hundred dollars per hour of cancelled or failed appointment time, returned checks with non-sufficient funds will be charged fifty dollars per each incident, and responsibility for payment for services provided for Patient in this office (including interest, administrative & collection fees) is mine.

Signature_____Date_____