PATIENT REGISTRATION FORM

The following confidential information is for our records only

Welcome to Dr. Abufaris's office. We sincerely appreciate you choosing our office for your health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Dr.
Mr.
Mrs._____**Date of Birth**_____
Miss.
Ms.

Home Address_____**City**_____**Zip**_____

Home#_____ **Work#**_____ **Cell#**_____

E-mail Address_____

Place of Employment_____**Social Security#**_____

Spouse's Name _____**S S#**_____**Spouse's Birthday**_____

Dental Ins. (Self)_____**Group #**_____

Address_____**Phone #**_____

Dental Ins. (Spouse)_____**Group #**_____

Address_____**Phone#**_____

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

Chief Dental Complaint_____

Who should we contact in case of emergencies?_____

AUTHORIZATION for TREATMENT: This is to certify that I, undersigned Patient or Guardian consent to all dental procedures agreed to between myself and Dr. Abufaris's office, including the use of local inhalational, sedative or general anesthesia as indicated, and I will assume complete responsibilities for all fees associated with those procedures. I agree that all fees are due and payable, in full, at the time services are rendered. Dr. Abufaris's office, at its discretion, may elect to assess me finance charges, not to exceed 1.5% per month, on any balances that are over 60 days past due.

_____
Patient (Guardian's) Signature