REGISTRATION

Dr. Michael J. Morgan
7 N. Grant Street
Hinsdale, IL 60521

PATIENT INFORMATION

first name | last name | nickname

gender | marital status | birthdate | ss#

address | city | state | zip

email

home phone | work phone | cell phone

whom may we thank for referring you to our office?

notify in case of emergency | phone

EMPLOYMENT

patient's employer | occupation

employer address

city | state | zip

INSURANCE

policy holder's name | birthdate | id#/ss#

address (if different from patients)

city | state | zip

policy holder's employer

insurance company | group #

insurance company address | phone

city | state | zip

AUTHORIZATION

I authorize and give consent to the performance of the dental services for myself (or my dependent). I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist of by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for payment of services rendered, regardless of insurance coverage.

patient signature | date