REGISTRATION FORM

PATIENT REGISTRATION FOR:____
FIRST NAME MIDDLE NAME LAST NAME

Residence Address: ____ __________
STREET ADDRESS APT. #

___________________________________ _______ _______-______
TOWN / CITY STATE ZIP CODE

Home Telephone: ( ) _____-________
Work Telephone: ( ) _____-________
Cellphone: ( ) _____-________
Email: ______________________________
Social Security Number: _____-___-_____
Date of Birth: _____/_____/_____
Preferred time for appointments:__________________
Referred by: _____________________
Other family members in practice:_________________
Marital Status: S M D W
Will you take calls at work? _____________________
Spouse's Name: __________________

If Minor, Name of Guardian: ____

Address & Telephone: ________________________ ( ) _______-_________

Student Status: F/T P/T N/A School Name: _____________________ City: __________________

Person Responsible for fee (If other than patient)________________Relationship to Patient __________

Social Security Number: _____-___-_____ Date of Birth: _____/_____/_____

Billing Address (If different from above)____

____

Employers Name: __________________
Occupation: ____________________________

Employment Address: ____ __________
STREET ADDRESS APT. #

___________________________________ _______ _______-______
TOWN / CITY STATE ZIP CODE

EMERGENCY NOTIFICATION

Nearest relative not living with you - Name & Telephone

____

PERMISSION TO TAKE PHOTOGRAPHS, SLIDES & VIDEOS

I, (print name) ________________________________, hereby authorize Drs. Jay & Janice Cazes, and their office staff to take photographs, slides, images and/or videos of my face, jaws and teeth.

I understand that the photographs, slides, images and/or videos will be used for educational purposes in lectures, demonstrations, and professional publications.

I further understand that if the photographs, slides, images and/or videos are used in any publication or as part of a demonstration, reasonable attempts will be made to conceal my identity.

____
Patient's Signature

____
If a Minor, Signature of Parent or Guardian

____
Witness Signature

____
Doctor's Signature

____
Date