James A. Pasternak, DDS
Chatsworth, CA

PATIENT REGISTRATION

Please print clearly and fill out both sides

Welcome to our office! We know that you will be pleased with your care. Prior to beginning treatment, the following information is necessary. Please complete this form fully and PRINT legibly. All information will be held in strict confidence. Thank you for making us your happy dental home!

How did you hear about us? (Whom may we thank for your referral?) _____

PATIENT INFORMATION

Name _____ Home Phone (_____)_____

Home Address _____City _____ State _____ Zip Code _____

Social Security Number _____ Birthday _____ Age _____ Sex _____ Drivers Lic. No._____

Employer _____ Work Phone (_____) _____ Extension _____

Business Address _____ City _____ State _____ Zip Code _____

Cell Phone (_____) _____ Pager (_____) _____ Occupation _____

Name of Spouse _____ Spouse's Employer _____ Phone (_____) _____

College Student: Name of School _____ City _____State _____

If patient is a minor, may we treat him or her in your absence should they come in for treatment at a regular appointment and you are unable to accompany them to the office? ☐ **Yes** ☐ **No**. No treatment other than that for which the minor is scheduled shall be performed at that visit if you are not present.

Person to contact in case of an emergency:

Name _____ Relationship: _____ Phone: (_____) _____

FOR PATIENTS COVERED BY DENTAL INSURANCE

Subscriber's Name _____ Birthdate _____ Home Phone (_____) _____

Employer _____ Work Phone (_____) _____

Work Address _____ City _____ State _____ Zip Code_____

Insurance Company _____ Group / Policy Number _____

Social Security Number _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Have you used this dental insurance previously? ☐ Yes ☐ No
Are you covered by more than one **dental** insurance? ☐ Yes ☐ No If **yes**, please complete the next section:

SECONDARY INSURANCE

Subscriber's Name _____ Birthdate _____ Home Phone (_____) _____

Employer _____ Work Phone (_____) _____

Work Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group / Policy Number _____

Social Security Number _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

CONSENT

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local anesthetic as may be deemed advisable by the dentist. I hereby authorize my dentist to release any and all dental and medical information to the above-named insurance carrier(s) for the purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I hereby authorize my Insurance Carrier to pay directly to the within-named dentist(s) the dental benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by insurance. I acknowledge the office policy that I must give forty-eight hours notice, **during business hours**, to change or cancel an appointment. Failure to do so may result in a charge to my account.

Signature _____ Date

_____
Patient (**Parent or Guardian for minor child)**