PATIENT REGISTRATION

Cameron C. Cho, D.D.S. • Pamela L. Schmidt, D.D.S.

To help us serve you better, please complete this confidential information

Name

Preferred Name

Address

City State Zip

SS# (only if billing insurance)

Sex M / F Date of Birth

Spouse

Date

Parent's Information for children

Name

Preferred Name

Address (if different)

City State Zip

Sex M / F Date of Birth

Spouse

In case of emergency, we should contact

NAME

PHONE

Contact Information

Home Phone

Work Phone

Cell Phone

Email Address

Other

Who may we thank

Referred to us by:

Is another member of your family a patient with us?

Name

Relationship

Account Information (Person financially responsible for account)

Name (if different)

Relationship to patient

Drivers License No.

You

Occupation

Employer

City

Your Spouse

Occupation

Employer

City

Business Phone

Dental Insurance

Primary Carrier

Insurance Company

Employee

Date of Birth Date Employed

Employee SS#

Secondary Carrier

Insurance Company

Employee

Date of Birth Date Employed

Employee SS#

We Respect Your Time

We make every effort to appoint you in a manner that maximizes your time with the doctor.

We Encourage Your Participation

We pledge to educate and inform you of your dental health choices. We believe together is the way to choose the best for your health. Your input guides your treatment.

We Promise You the Best of Modern Dentistry

Dentistry today offers many advanced treatment choices. Properly applied, these treatments can **look fantastic, feel great and serve you for a long time**. We pledge to use no shortcuts with your health and to meticulously apply all this modern technology. We promise to bring you the best of the art and science of modern dentistry.

We Care about Your Safety

Your health and peace of mind are of the utmost importance to us. We use the infection control techniques recommended by the American Dental Association and the Center for Disease Control.

We Value Your Choice

Thank you for placing your trust in us. We are committed to giving you a high quality dental experience and exceeding your expectations because we believe you deserve the best care.

Consent for Treatment

1. I hereby authorize doctor or designated staff to take mutually agreed upon x-rays, study models, photographs, and any other diagnostic aid deemed appropriate by doctor to make a thorough diagnosis of myself (or my child's) dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that monthly accounting fees of $25 to $200 may be added to my account.
5. I have been informed of a $35 returned check fee.
6. I understand I am responsible for all charges, including charges not covered by my insurance carrier.

Patient ____ Date ________________ Witness ____________________________

Parent or Responsible Party ____ Relationship to Patient ___________________