Dr. Tim Kirkpatrick

Family & Cosmetic Dental Office

11040 W. Bluemound Rd, Suite 201
Wauwatosa, WI 53226
(414) 476-4777

Welcome

PATIENT REGISTRATION

Patient's Name ______________________ **Date of Birth** __________ **Male** **Female**

Last First Initial

If child, Parent's Name: ______________________

How do you wish to be addressed: ______________________

Single Married Separated Divorced Widowed Minor

Residence - Street ______________________

City ______________ State ______ Zip ________

Business Address ______________________

Telephone Res. ______________ Bus. ____________

Fax ____________ Cell Phone ______________

Email ______________________

Patient/Parent Employed By ______________________

Present Position ____________ How Long Held ________

Spouse Employed By ______________________

Present Position ____________ How Long ________

Who is Responsible for this Account ______________________

Drivers License No. ______________________

Method of Payment: Insurance Cash Credit Card

Purpose of Call ______________________

Other Family Members in this Practice ______________________

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Whom may we thank for this referral ______________________

____

Patient/Parent Social Security No. ______________________

Spouse/Parent Social Security No. ______________________

Someone to notify in case of emergency (not living with you):

____

Dental Insurance - 1st COVERAGE

Employee Name ______________________

Date of Birth __________ Relationship to patient __________

Employer Name ______________________

Name of Insurance Co. ______________________

Address ______________________

Telephone ______________________

Policy # ______________________

Social Security No. ______________________

Union Local or Group No. ______________________

Dental Insurance - 2nd COVERAGE

Employee Name ______________________

Date of Birth __________ Relationship to patient __________

Employer Name ______________________

Name of Insurance Co. ______________________

Address ______________________

Telephone ______________________

Policy # ______________________

Social Security No. ______________________

Union Local or Group No. ______________________

Consent:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. ***I consent*** to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. ***I consent*** to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing. ***I authorize*** payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. ***I attest*** to the accuracy of the information on this page.

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PATIENT'S OR GUARDIAN'S SIGNATURE DATE

...providing exceptional gentle personalized care!