

Registration Form



Date _____

Patient _____
First name Middle initial Last name Preferred name

Street address _____

City, State, Zip code _____

Phone numbers & email: Preferred contact method _____

Home _____ Work _____ Cell _____

Email address

Married _____ Single _____ Minor _____ Male _____ Female _____

Birth date _____

Social security number _____

Employer _____ Occupation _____

Employer address _____

Spouse name _____ Spouse birth date _____

Spouse employer _____ Occupation _____

Dental Insurance Information (if applicable):

Insured _____

Employer _____

Name of dental insurance company _____

Dental insurance company claim address _____

Group number for policy _____

Social Security number or i.d. of policyholder _____

Birth date of policyholder _____

Emergency contact and phone number _____

Who may we thank for referring you? _____

Authorization:

I understand that I am responsible for all costs of dental treatment. I hereby authorize High Desert Dental, Joshua M. Eastham, DMD to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical history and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer.

Patient or Parent _____

High Desert Dental

Joshua M. Eastham, DMD