Registration Form

Date_____Patient _____

First Name Middle Initial Last Name Preferred Name

StreetAddress_____

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 Eastham, DMD