STEPHEN MARON, D.D.S., M.P.H.
9535 RESEDA BLVD., SUITE 207
NORTHRIDGE, CA 91324

COMPREHENSIVE DENTAL CARE
TEL: 818.886.3488 FAX: 818.886.3498
www.SMaronDDS.com

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE.

DATE			REFERRED BY				
LAST NAME				FIRST NAME			M.I.
PREFERS TO BE CALLED BY							
ADDRESS							
CITY				STATE		ZIP	
HOME PHONE			WORK PHONE			WORK PLACE	
BIRTHDATE	AGE	MALE	FEMALE	MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY #							

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE.

DATE					
LAST NAME			FIRST NAME		M.I.
PREFERS TO BE CALLED BY					
ADDRESS					
CITY			STATE	ZIP	
HOME PHONE					
BIRTHDATE	AGE	MALE	FEMALE		
SOCIAL SECURITY #					

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS FILL IN THE TOP BOX ALSO.

DENTAL BENEFITS

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT	S.S.#	
ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER		

FINANCIAL RESPONSIBILITY OF ACCOUNT TO BE PAID BY:
PLEASE CHECK ONE OF THE FOLLOWING.

CREDIT CARD ☐ MC ☐ VISA ☐ DISCOVER

CREDIT CARD #

EXPERATION DATE

PAYMENT PLAN

I UNDERSTAND THAT MY ABOVE ACCOUNT WILL BE CHARGED FOR MY DENTAL TREATMENT IF MY DENTAL INSURANCE FAILS TO PAY WITHIN 45 DAYS OF MY TREATMENT

SIGNATURE DATE

DENTAL BENEFITS

Primary Carrier

INSURANCE COMPANY	
GROUP NAME	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NUMBER	
INSURED'S SOCIAL SECURITY #	

Secondary Carrier

INSURANCE COMPANY	
GROUP NAME	
EMPLOYER NAME	
INSURED'S NAME	RELATIONSHIP TO PATIENT
DATE OF BIRTH	
INSURED'S I.D. NUMBER	
INSURED'S SOCIAL SECURITY #	

Please complete other side

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ________________________________'s dental needs.

2. Upon such diagnosis, I authorize doctor to preform 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 a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's signature ________________________________ Date ______________ Witness ________________________________

Parent/Responsible Party's signature ____________________________ Relationship to Patient ________________________