**CRAIG W. JACKSON, DDS, PA**
**REGISTRATION FORM**

Patient's Name _____ Date of Birth __/ __/ __ M F

If Child: Parent's Name _____

How do you wish to be addressed? _____ Marital Status _____

Mailing Address _____City _____ State ____ Zip Code _____

Email Address _____

Home Phone _____ Business Phone _____

Cell Phone _____ Primary choice of contact: (circle one) Home Business Cell Email

Spouse Name _____ Contact phone _____

Emergency Contact _____ Contact phone _____

Social Security No. _____ Spouse Social Security No. _____

Whom may we thank for this referral? _____

Other family members in this practice? _____

Primary purpose of your visit today _____

Primary Dental Insurance Co. Name _____ ID or Subscriber No. _____

Employee Name _____ Date of Birth __/__/__ Relationship to patient _____

Employer Name _____Group No. _____

Secondary Dental Insurance Co. Name _____ ID or Subscriber No. _____

Employee Name _____ Date of Birth __/__/__ Relationship to patient _____

Employer Name _____ 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 of disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and healthcare operations that are related to treatment of payment. I consent to 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 of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits ay 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 all information provided.

**PATIENT'S OR GUARDIAN'S SIGNATURE**

_____ Date _____